

Shalom Court Auckland Incorporated - Shalom Court 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 and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

| | |
|---|--|
| Legal entity: | Shalom Court Auckland Incorporated |
| Premises audited: | Shalom Court Rest Home |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 28 March 2017 End date: 29 March 2017 |
| 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: | 36 |

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Shalom Court Rest Home and Hospital is a not-for-profit organisation that is governed by a board of management, and managed by an executive office with 15 years of experience within Shalom Court. The service provides rest home and hospital level of care for up to 36 residents. On the day of the audit there were 36 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observation, and interviews with residents, management, staff, board members, rabbi, resident advocate, physiotherapist and the general practitioner.

A resident services manager is responsible for the daily clinical operations of the service. She is supported by a clinical lead and stable workforce. The residents and community visitors spoke highly of the service, including the provision of a supportive cultural and spiritual environment based on Jewish values and beliefs.

There is one area for improvement around enabler consents.

The service has been awarded continuous improvement ratings for recognition of individual values and beliefs, and governance.

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. | | All standards applicable to this service fully attained with some standards exceeded. |
|--|--|---|

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support resident rights. Care planning accommodates individual choices of residents and/or their families. Residents are encouraged to maintain links with the community. Complaints processes are implemented and complaints and concerns are managed appropriately.

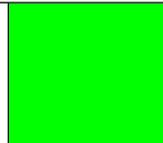
Organisational management

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

Shalom Court Rest Home and Hospital has an implemented quality and risk management system. Key components of the quality management system include: management of complaints; implementation of an internal audit schedule; annual satisfaction surveys; incidents and accidents; review of infections; review of risk; and monitoring of health and safety including hazards. The three-monthly quality/health and safety/infection control committee meeting includes discussion around quality data. Human resources policies are in place, including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. The education programme includes mandatory training requirements.

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.

A registered nurse is responsible for the provision of care and documentation at every stage of service delivery. Information gained through the initial support plans, specific assessments, discharge summaries and the care plans, guide staff in the safe delivery of care to residents. The care plans are resident centred and reviewed every six months or earlier if required, with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents three-monthly in the rest home and one monthly in the hospital.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and healthcare assistants who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

The food service is contracted. There is a separate kosher kitchen where foods are prepared for the monthly kosher lunches. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

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

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The two buildings hold a current warrant of fitness. All residents' rooms have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are monitored through the internal auditing system. All but personal laundry is contracted out. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

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

There are policies and procedures in place that include the definition of enablers and instructions to follow in the event that restraint is required. There were no residents using restraints and two residents using an enabler. A registered nurse is the restraint coordinator. Staff receive training around restraint and challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

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 | 1 | 43 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 2 | 90 | 0 | 1 | 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 | Seven residents (four rest home and three hospital level of care) interviewed confirmed that information has been provided around the Code of Rights. Residents stated their rights are respected when receiving services and care. There is a resident rights policy in place. Staff attend Code of Rights training. Discussion with three healthcare assistants (HCA) and three registered nurses (RN) identifies that they are aware of the Code of Rights and can describe the key principles of resident's rights when delivering care. |
| 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 | The service has in place a policy for informed consent and resuscitation. Completed resuscitation forms are completed on all six resident files reviewed. General consent forms are evident on files reviewed. Discussions with staff confirms that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed with the admission agreements. All resident's files sampled had signed admission agreements on file. |
| Standard 1.1.11: Advocacy And | FA | Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the |

| | | |
|--|----|--|
| <p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | | <p>admission process. Pamphlets on advocacy services are available in the entrance to the facility. Interviews with the residents confirmed their understanding of the availability of advocacy services. The resident advocate (interviewed) visits regularly and has multiple roles in Jewish and other voluntary organisations. Staff receive education and training on the role of advocacy services. Staff are aware of the resident's right to advocacy services and how to access the information.</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> | FA | <p>The service has an open visiting policy and family/whānau, friends and community are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirm that family and friends are able to visit at any time. Many friends and community visitors were observed attending the home on the days of audit. Residents confirm that they have been supported and encouraged to remain involved in the community. Community groups visit the home as part of the activities programme.</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> | FA | <p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints is maintained by the resident services manager using a complaints' register. There were sixteen complaints in 2016 including one received by the DHB and one involving the Health and Disability Commissioner. Both complaints were closed with no further action. All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidences resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments are evident in facility meeting minutes.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>The service has available information on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) in the main entrance to the facility. The Code is displayed and advocacy information is available. There is a welcome information folder that includes information about the Code. The resident, family or legal representative have the opportunity to discuss this prior to entry and/or at admission with the executive officer or resident services manager. Residents confirm that they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p> | FA | <p>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff are able to</p> |

| | | |
|--|----|--|
| <p>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>describe how they maintain resident privacy. Staff sign a code of conduct declaration and information technology policy on employment. Staff attend privacy and dignity and abuse and neglect in-service training as part of their education plan. Care staff state that they promote independence with daily activities where appropriate. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan to ensure the resident receives services that are acceptable to the resident/relatives.</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> | FA | <p>There is a Maori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The Maori health plan identifies the importance of whanau. Currently there are no residents who identify as Maori. The executive officer, resident services manager, RNs and HCAs are able to describe how to access information and provide culturally safe care for Maori. The provider has links with the local Kaumatua who has been previously involved in the blessing/opening of the hospital wing.</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> | CI | <p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular religious services and are supported to attend other community groups as desired. The service is successful in providing culturally safe care for the elderly Jewish residents, based on Jewish religious values and beliefs.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>The staff employment process includes the signing of a service code of conduct. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on a sense of trust, faith, security and self-esteem. Interviews with RNs and HCAs could describe how they build a supportive relationship with each resident. Residents state they are treated fairly and with respect.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The management team are committed to providing a faith based service of a high standard, based on the Shalom Court mission and philosophy. This was observed during the audit with the staff demonstrating a caring attitude to the residents. All residents and visiting community members spoke positively about the care provided. The service has implemented policies and procedures</p> |

| | | |
|--|----|---|
| | | that provide a good level of assurance that it is adhering to relevant standards. Registered nurses and HCAs have access to internal and external education opportunities. Staff have a sound understanding of principles of aged care and state that they feel supported by management. The service contracts a physiotherapist ten hours a week over two days. The physiotherapist (interviewed) completes an initial mobility assessment on all residents and reviews residents of concern and post falls as required. |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The management team promotes an open-door policy. Relatives are aware of the open-door policy and confirm that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through monthly resident meetings which are taken by the resident advocate. Annual surveys also provide residents/relatives with an opportunity to provide feedback. Eleven accident/incident forms reviewed (two rest home and nine hospital level) document that relatives are informed of any incidents/accidents. Residents and family are informed prior to entry of the scope of services, and any payable services not covered by the agreement. An interpreter service is available if required. |
| Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Shalom Court Rest Home and Hospital is a faith based not-for-profit organisation and governed by a board. The service provides rest home and hospital level of care for up to 36 residents. There are ten rest home cottages in a separate building on the site closely located to the main facility. The main facility has a hospital wing of 12 beds and another wing of 14 dual purpose beds. On the day of audit, there were 19 rest home residents and 17 hospital level of care residents. There were five hospital and nine rest home level of care residents in the dual-purpose beds. All residents are under the age-related residential care contract. There were no respite residents. The executive officer (EO) has been involved in Shalom Court for 15 years in various management and board roles. The EO is part-time for 18 hours per week and leads the executive team who report to the board. The resident services manager/registered nurse has been in aged care for seven years of which one year and eight months has been at Shalom Court. She is supported by an executive assistant (non-clinical) and clinical lead/registered nurse. There is a strategic business plan 2013–2018 that is reviewed regularly. This non-profit organisation has been successful in achieving its vision, mission and philosophy around providing care based on Jewish values and beliefs (link CI 1.1.6.2), widening Shalom's profile within the |

| | | |
|---|----|---|
| | | <p>community and achieving sustainability.</p> <p>The EO has a business degree and maintains professional development related to a governance role including attending provider meetings and a two-day aged care conference. The resident services manager has attended at least eight hours of professional development including attending aged care conference and leadership seminars, interRAI managers training and palliative care modules. The EO and resident services manager attend the DHB cluster meetings for providers.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>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.</p> | FA | <p>During the temporary absence of the resident services manager, the clinical lead provides clinical and management oversight of the facility including the on call requirement. Both the resident services manager and clinical lead have a current practising certificate.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery, both have been reviewed regularly by the service. Combined quality/health and safety/infection control meetings are held quarterly and include discussion around quality data including: complaints, compliments, health and safety, accident/incident, infection control, internal audit and survey results. Trends are identified and analysed for areas of improvement. Staff interviewed confirm they are kept informed on all areas of service including quality data. Meeting minutes and quality data is displayed for staff. There are clinical and staff meetings that are held on a regular basis. A full quality/risk management report is forwarded to the board.</p> <p>Internal audits cover all areas of service and are completed as scheduled. Corrective actions are raised for any areas of non-compliance. An annual resident/relative survey has been completed. Letters sent out by the EO (sighted) thanked participants for their responses and informed them on the outcomes of the survey.</p> <p>The board members and EO have completed an update to the new health and safety plan following the new legislation. The Health and Safety (H&S) Committee comprises of representatives (four interviewed) across the services. One health and safety representative is registered to attend transition training. The Health and Safety Committee review monthly accident/incident reports, hazard reports and register. Staff have the opportunity to discuss any concerns with the representatives prior to H&S meetings. Incident forms identify an event owner</p> |

| | | |
|---|----|---|
| | | <p>who completes, monitors and evaluates the incident. Contractors receive a letter prior to being on-site and complete a work safety permit. Staff have received education on the H&S changes. The staff H&S noticeboard displays information on H&S.</p> <p>Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case by case basis to minimise future falls.</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> | FA | <p>There is an accident/incident policy as part of risk management and health and safety framework. Eleven incident forms (two rest home and nine hospital) were reviewed from January 2017. All incident forms identify timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations have been completed for unwitnessed falls and any known head injury. The next of kin have been notified for all incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The resident services manager collects incident/accident forms, completes investigations and implements corrective actions as required.</p> <p>The EO and resident services manager described situations that would require reporting to relevant authorities. One security breach has been reported to the relevant authorities.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>There are human resources policies to support recruitment practices. The register of RN's practising certificates and allied health professionals is current. Eight staff files were reviewed (resident services manager, clinical lead/RN, two RNs, three HCAs and one maintenance person). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff interviewed were able to describe the orientation process and believe new staff are adequately orientated to the service.</p> <p>Registered nurses and HCAs are supported to attend external education. All six RNs have completed interRAI training. Staff complete competencies relevant to their roles. The education plan covers the required mandatory training requirements.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p> | FA | <p>The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The resident services manager and clinical lead are on duty during the day Monday to Friday and share the on-call. There is a RN on duty 24 hours. There is a second RN on duty six</p> |

| | | |
|---|-----------|---|
| <p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | | <p>hours per day Monday to Friday, to oversee the rest home residents and the cottages. There is one HCA allocated to the rest home cottages 24 hours.</p> <p>The resident services manager has tendered her resignation and the clinical lead will cover for three weeks until the new appointment commences on 24 April 2017. The new appointment has experience in aged care as a nurse manager.</p> <p>Residents and relatives state there are adequate staff on duty at all times. Staff state they feel supported by the executive team and management team who respond quickly to after-hours calls.</p> <p>Linen is laundered off-site. Food services staff are contracted.</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>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record. Residents' clinical and allied health records are integrated. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</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>There are policies and procedures to safely guide service provision and entry to services including an admission policy.</p> <p>The service has an information pack available for residents/families at entry. The admission agreement meets the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Six admission agreements are all signed and dated.</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>Policies in place describe guidelines for death, discharge, transfer, documentation and follow ups. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a</p> | <p>FA</p> | <p>There are comprehensive policies and procedures in place for all aspects of medication management. There were two residents self-administering medications on the day of audit. Both residents have been deemed competent and the medications are stored in locked drawers. An RN</p> |

| | | |
|---|-----------|---|
| <p>safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>or medication competent healthcare assistant checks that medications have been taken as prescribed.</p> <p>The facility uses a robotic pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses or healthcare assistants who have passed their medication competency, administer medications. Medication competencies are updated annually and staff attend annual education. The facility uses standing orders. These meet legal requirements. The medication fridge temperature is checked nightly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on medication signing sheets. Twelve medication charts were reviewed (six rest home and six hospital). Medications are reviewed by the GP at least three-monthly. All medication charts have photo identification and allergy status recorded. 'As required' medications have prescribed indications for use.</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>A contracted service provider provides all meals from the on-site kitchen. There is one head chef, two cooks and two kitchen hands who cover the provision of meals across the seven-day week. All food services staff have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. There is a well equipped kitchen and all meals except for kosher food are cooked in the on-site kitchen. Meals are served from bain maries in the kitchenettes of each wing. In the Shalom Court cottages' kitchen, there is a separate area kept for the preparation of kosher food. Special equipment such as lipped plates are available. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked before food is served. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are known. The four-weekly menu plans have been audited and approved by an external dietitian. Audits are implemented to monitor performance. A recent food satisfaction survey identified areas for improvement and the executive team have been actively engaging with the food service team and residents to improve services. Five of the executive team members join residents for a main meal weekly. On the day of audit, meals were observed to be well presented.</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 | <p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The service would decline entry to services if it was unable to provide the assessed level of care or there were no beds available. Potential residents would be referred back to the referring agency.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>There are up-to-date interRAI assessments completed in all six files sampled and these have been completed within the required timeframe. There is a clear link between the interRAI assessments and the care plans. InterRAI assessments have been completed when there has been a significant change in a resident's health status. Additional assessments for management of wound care and cultural/religious needs are appropriately completed according to need.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Care plans evidence multi-disciplinary involvement in the care of the resident. All care plans are resident centred and document support needs to achieve the resident goals. Seven residents interviewed stated that they are involved in the care planning process.</p> <p>Short-term care plans are used for changes in health status and are evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan as needed. There is evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, dietitian, geriatrician and mental health care team for older people.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>The six care plans reviewed include documentation that meets the need of the residents. Care plans have been updated as residents' needs change. When a resident's condition changes, the RN will initiate a GP consultation. Changes in care are also documented in the progress notes and communicated at handovers. Staff state that they notify family members about any changes in their relative's health status. Seven residents interviewed stated that care delivery and support by staff is consistent with their expectations.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>There is currently one wound (a left lateral leg ulcer) and two facility acquired pressure injuries (one stage I and one stage II). All wounds have appropriate care documented. The registered</p> |

| | | |
|--|----|---|
| | | <p>nurses state that they have access to specialist wound care advice if required.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviour.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The planned activities are organised and run by an events management subcommittee reporting to the executive team. This committee includes a healthcare assistant who also holds a role as the activities coordinator. On the days of audit, residents were observed being actively involved with a variety of activities including exercises, balloon games and a birthday morning tea. The mobile dentist also visited. Those residents who prefer to stay in their room have one-on-one visits for a chat and to check if there is anything they need.</p> <p>There is a large print copy of the monthly and weekly programme on the noticeboard in all areas. Residents and families also receive a personal copy. There are van outings monthly (the van is hired) and entertainers visit at least monthly. Special events like birthdays, Mothers' Day, Anzac Day, Melbourne Cup and Jewish celebrations/festivals are celebrated.</p> <p>The hard of hearing have talking books and those with macular degeneration may use the Topaz screen.</p> <p>The rabbi visits monthly and at any other time when needed. Nuns come in weekly to give communion and the priest visits as needed. On occasions the rabbi, priest and minister join together for an interdenominational service.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Resident files identify that the activity plan is based on this assessment. Activity plans have been evaluated six-monthly.</p> <p>Shalom Court is very community focused and outside group and families are welcome to use the facility's communal areas. The seven residents interviewed stated that they enjoy having the outside world come into them.</p> <p>Resident's feedback on the activities programme at the monthly residents' meetings. The event management sub-committee meets annually to review the programme.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p> | FA | <p>The six care plans reviewed have been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short term needs such as a urinary tract infection have been evaluated and signed off as resolved or added to the long-term care plan as</p> |

| | | |
|---|-----------|---|
| <p>evaluated in a comprehensive and timely manner.</p> | | <p>an ongoing problem. Activities plans are in place for each resident and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is evidence of family members being informed of any changes to the care plan on the family communication form and in the progress notes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>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> | <p>FA</p> | <p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples include: one resident who had been referred to Mental Health Services for Older People and another to the dietitian. Discussion with a registered nurse identifies that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>There are policies in place regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas in all areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicate a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff. The maintenance person described the safe management of hazardous material.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>The main building and rest home cottage building both hold a current warrant of fitness until 31 March 2018.</p> <p>There is a planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. The hoists and scales have been checked, tagged and calibrated. Hot water temperatures are monitored three-monthly in resident areas and are within the acceptable range. The communal lounges, dining rooms, hallways and resident rooms are carpeted. Utility areas such as the kitchen, laundry, sluice rooms and ensuites have vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. The cottages have concrete walkways and wooden rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well</p> |

| | | |
|---|----|--|
| | | maintained. There are outdoor areas with seating and shade for each wing. There is safe access to all communal areas. |
| <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 | All rooms have ensuites. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. There is ample space in all toilet and shower areas to accommodate shower chairs and hoists if required, in the hospital and dual purpose wings. |
| <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 | Residents' rooms are spacious and allow the safe use of mobility aids. Staff report that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the days of audit. |
| <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 | Activities occur in the spacious communal lounges. Seating and space is arranged to allow both individual and group activities to occur. There are areas where residents who prefer quieter activities or visitors may sit. The dining rooms are part of the communal lounges and there is adequate space for this. |
| <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 | Personal laundry is undertaken on-site by the healthcare assistants. Healthcare assistants interviewed stated that they manage the workload well. All other laundry is done off-site. There are appropriate systems for managing infectious laundry which the healthcare assistants could describe. There is a comprehensive laundry and cleaning manual. Cleaning services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboards as sighted on the days of audit. There are two sluice rooms for the disposal of soiled water or waste. The sluice rooms and the laundry are kept locked when not in use. |

| | | |
|---|-----------|--|
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>FA</p> | <p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available including adequate food and water storage for at least three days. There is emergency power back-up and the service is on high priority for the hire of a generator.</p> <p>The fire evacuation scheme was approved by the Fire Service 8 September 1999. There are six-monthly fire drills. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>The service has upgraded the call bell system throughout the facility which is also linked to the rest home cottages. Resident's rooms, communal bathrooms and living areas all have call bells. Call bell pendants and wristwatches are provided. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. There is surveillance cameras installed and the building is secure after hours.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | <p>FA</p> | <p>The facility has ample natural light and ventilation. In the hospital wing, there is underfloor heating. In the dual-purpose wing, there is gas heating in hallways and communal areas and electrical heating in residents' rooms. In Shalom Court cottages, the heating is electric. Staff state that the heating is effective. There is a small area allocated to smokers but the rest of the facility is smokefree.</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 infection control coordinator (RN) oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to the combined Infection Control/Health and Safety Committee and executive team.</p> <p>The infection control programme has been reviewed and any areas for improvement are linked to the quality system.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. There are adequate supplies of personal protective equipment.</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> | FA | <p>The RN infection control coordinator has attended external education provided by an infection control consultant in April 2016. The Infection Control Committee comprises of representatives across all service areas. A board member is on the Infection Control Committee.</p> <p>The infection control coordinator has access to GPs, local laboratory, the DHB infectious disease specialists, Public Health Department and an external infection control consultant specialist.</p> |
| <p>Standard 3.3: Policies and procedures</p> <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.</p> | FA | <p>The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by the infection control coordinator with the use of a reference manual developed by an external consultant. Policies and procedures were last reviewed February 2017.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control and a handwashing audit is included in orientation and as part of the annual training schedule. Current and topical information is displayed on the infection control noticeboard. Hand hygiene competencies are completed on orientation and are ongoing. The infection control coordinator also conducts on the spot audits, questions and word finders around infection control.</p> <p>Resident education is expected to occur as part of providing daily cares, as appropriate.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information monthly through surveillance to determine infection control activities and education needs in the facility. Data is analysed for trends and a quarterly report is provided to management and staff including graphs with monthly comparisons for all types of infections using the standardised definitions for infections. Preventative measures are put in place for identified trends.</p> |

| | | |
|--|---------------|--|
| | | <p>Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>PA Low</p> | <p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for the use of enablers and restraint. A registered nurse is the restraint coordinator with a defined job description.</p> <p>On the day of the audit, there were no residents with restraint and two residents (hospital) with enablers. Two of two files reviewed identified enabler assessments, care plan interventions, enabler monitoring and reviewed six-monthly. Two of two consent forms had not been signed by the resident.</p> <p>Restraint and challenging behaviour education is included in the training programme.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|-------------------|--|---|--|
| <p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p> | PA Low | Consents are in place for two residents using enablers, however, the resident’s relative had signed each consent form. | The two residents with enablers had not voluntarily signed the consent form and the enduring power of attorney of both residents, had not been enacted to allow the relative to sign for the enabler. | <p>Ensure residents sign for voluntary consent of an enabler.</p> <p>90 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|---|-------------------|---|--|
| <p>Criterion 1.1.6.2</p> <p>The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.</p> | CI | <p>The service recognises the importance of the rabbi and resident advocate in meeting the Jewish resident's values and beliefs. Staff are knowledgeable in the provision of culturally safe care for Jewish residents.</p> | <p>The service provides care for elderly Jewish residents who make up 35% of the resident occupancy. The service is governed by a board and executive officer who actively represent the Jewish residents and community. All staff have education on Judaism during their orientation and ongoing as part of the education plan. All Jewish festivities are celebrated and residents of other faiths are invited to attend. There is a monthly kosher lunch with the rabbi. The rabbi (interviewed) stated that the board, executive officer and staff do their utmost to meet the philosophy of care for the Jewish residents. There is a separate designated kitchen for the preparation and cooking of the kosher lunches which is undertaken by volunteers and staff. Jewish foods are brought in especially for Passover. Volunteers lead Kiddush blessings and prayers on Friday evenings and for Jewish festivals. Residents, the resident advocate, volunteers and board members interviewed confirm that the residents' cultural values and beliefs are being met. Staff are knowledgeable around Judaism and can describe how residents' values and beliefs are being met. Care plans identify cultural and religious beliefs. The resident/relative survey was positive around the service meeting resident values and beliefs.</p> |

| | | | |
|---|-----------|---|---|
| <p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p> | <p>CI</p> | <p>The home was funded in 1976 and is owned and operated by a charitable trust. The provider has been successful in achieving its stated values, mission and philosophy of care based on Jewish values and beliefs. The provider has increased its profile with the Jewish community and stakeholders which has led to sustainability of the service.</p> | <p>Two years ago (June 2015) there was a restructure of the governing body with the development of a board and executive team. All board members attended a seminar that outlined their roles. Board members actively interact with residents, staff and stakeholders and take on other roles such as attending the Health & Safety Committee meetings, maintaining an asset register, involvement in activities and Jewish festivities. The rest home cottages were reduced from 16 to 10 which then allowed six cottages to be available to accommodate visiting family, religious visitors and for families in need. The provider has increased its profile within the community and extends invitations to the Jewish community (and other faiths) to attend kosher lunches, entertainment and festivities. Board members, the EO, executive team and rabbi cater, cook and prepare kosher meals for the monthly kosher lunch and other festivities. Shalom Court have a FOSCA (Friends of Shalom Court Auckland) membership in place. All members are invited to join in festivities and receive quarterly newsletters. Shalom Court and its brand (captured in its unique mission) is well known in the marketplace and among health professionals. The occupancy for the past 12 months has been 94-100%. The EO submitted an entry in the 2016 Aged Care conference awards called 'Innovation – the core of outstanding care – is ignited from our hearts'. The submission also summarised stakeholder outcomes. The provider was awarded the 'Small Operator Industry' award. The resident/relative survey and interviews with residents, volunteers, board members, EO and rabbi confirm the service has been successful in meeting its mission, values and beliefs for its Jewish residents, community and stakeholders.</p> |
|---|-----------|---|---|

End of the report.