# Seadrome Limited - Seadrome Home & Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Seadrome Limited

**Premises audited:** Seadrome Home & Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

**Dates of audit:** Start date: 4 September 2017 End date: 4 September 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:** 43

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

This surveillance audit was conducted against a sub set of the Health and Disability Service Standards and components of the service contract with the District Health Board (DHB). Seadrome Home and Hospital provides rest home and hospital level care for residents with dementia. There have been no changes to the facility or services since the last certification audit. Management continues to implement a range of quality projects and maintains continuous improvement activities.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family, management, staff and the general practitioner.

Three areas of non-conformance were identified during the audit. Improvements are required regarding nursing interventions, timeframes for the completion of long term care plans and the medicine management system. Previously identified areas requiring improvement have been addressed.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The organisation involves family members on issues of consent, for those who are assessed as not competent.

Management and staff take all complaints and concerns seriously and there is a transparent and implemented complaints management process.

## Organisational management

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| 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. |

The organisation is governed by the directors/owners. Day to day operations are the responsibility of an experienced facility manager. Organisational performance is monitored. The mission and strategic goals are documented and reviewed.

Quality and risk management systems support service delivery. Achievement towards quality goals is measured. Quality projects and innovations are continually implemented to achieve improved outcomes. The required policies and procedures are documented, reviewed and controlled. Quality related data is communicated, analysed and improvements made when required.

All staff are suitably trained. Competencies are assessed and performance is monitored. There is a sufficient number of experienced and qualified staff on each duty.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Registered nurses are responsible for the development of care plans with input from the residents, staff and family/whanau representatives. Care plans and assessments are developed and evaluated.

Planned activities are appropriate to the residents’ assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

Medication is administered by staff with current medication competencies. All medicines are reviewed by the GP every three months.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## Safe and appropriate environment

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| 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. |

There have been no changes to the facility since the last audit. Fire evacuations are conducted every six months as required.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There are clear and comprehensive documented guidelines on the use of restraint, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. The secure gate at the entrance to the facility has been approved and meets the requirements for environmental restraint. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education.

## Infection prevention and control

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| 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 surveillance programme is appropriate to the size and scope of the service.

## 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 | 14 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 35 | 0 | 2 | 1 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Information about the complaints process is provided to residents and family on admission. The process and forms are available in the entrance foyer. The resident's right to complain is discussed with the resident and family. Interviews with residents and family confirmed awareness of their right to make complaints if they wish.  The complaints register and associated records indicate effective and timely handling of complaints in accord with Right 10 of The Code. The register includes the date, nature of complaint, action taken and resolution. The register also provides evidence of transparency, apologies and open disclosure. There have been no formal (written) complaints since the last certification audit and none reported to the Health and Disability Commissioner. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Communication channels are defined. Interviews with staff and family members confirmed that communication is conducted in an open manner. Resident and family surveys are conducted and any issues raised are followed up and remedied promptly. There is evidence in resident records that family members are contacted if there is a change in a resident's health status. There is a cultural mix of staff who can converse in a number of languages. Additional interpreter services can be accessed 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 | The organisation is governed by two directors/owners. The mission and goals are displayed at the front entrance of the facility. The mission and goals are regularly reviewed and are appropriate for an aged care facility providing residential care for people with dementia at rest home and hospital levels.  Organisational performance is monitored in an ongoing manner. The facility manager meets with the directors on a weekly basis. Meeting minutes confirmed management reports on organisation performance and confirmed discussions regarding residents, programmes, infection control, adverse events, the facility and finances.  The facility manager is a registered nurse and has been in the position for 26 years. The facility manager has previous experience in the care of older people and dementia and maintains training hours in management and nursing scope of practice. Training in the last year included dementia Auckland annual symposium, attendance at a workshop in person centred planning in dementia, interRAI and palliative care training. The previous assistant manager continues to provide support on an as required basis. A new clinical lead has recently been employed.  Seadrome provides a secure unit of 25 beds for residents with dementia who are able to mobilise independently, and 20 hospital beds for residents with dementia who are unable to mobilise independently. There were 43 residents at the time of audit, 25 in the dementia unit and 18 in the hospital. Additional contracts are held with the DHB for the provision of respite and day stay services. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk management framework is defined. This includes a description of quality goals and quality related activities. The organisation implements a quality cycle to continually review and improve services. Organisational policies and procedures reflect standards, contracts, best practice, legislation requirements and are readily available to staff. All policies are subject to reviews and all policies sampled were controlled documents.  Service delivery is monitored through complaints, surveys, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. The results of internal audits are discussed at monthly quality team meetings (CQI). Staff are informed of quality improvements and corrective actions.  A risk management programme is in place. This includes health and safety policies and a health and safety plan. The health and safety programme is currently under review to better reflect changes in the current legislation. There is a hazard/risk management programme which is also being updated as part of the health and safety review. Business, clinical and financial risks are monitored. There is a well-documented risk management plan which was last reviewed in March of this year. The risk management plan covers the scope of the organisation.  The previous corrective action regarding quality related data has been addressed. Quality data is analysed by an external consultant and is providing Seadrome with meaningful data from which to plan and evaluate services. |
| 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 | The facility manager was aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, missing persons and completion of Section 31 notifications to the Ministry of Health. Recent events sampled confirmed that essential notifications to external authorities are made.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistake. Staff receive education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.  Incident reports were reviewed. Each incident report had a corresponding note in the progress notes to inform staff of the incident. There previous corrective action regarding notifying family and the facility manager in the event of an incident has been addressed. The required notifications were sighted in incident reports sampled. |
| 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. | FA | All registered nurses and managers hold current annual practising certificates. Evidence of visiting practitioners’ practising certificates is also maintained.  All staff have an orientation which includes the essential components of service delivery. This includes training on clinical emergencies, competencies and the management of challenging behaviour. Staff who administer medications have the required competency assessments and there is a staff member on each duty with a current first aid certificate. All staff complete the required unit standards on dementia. An induction process was also implemented for casual/agency staff.  Staff files include appointment documentation inclusive of criminal vetting and reference checks. In-service education is held regularly as per the training plan. Education and training hours exceed eight hours a year for each staff member. Staff confirmed they have access to sufficient training opportunities.  Staff performance is monitored, and annual performance appraisals were sighted in records sampled.  The previous corrective action regarding the management of staff records has been addressed. The required staff records were sighted in files sampled. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented staff policy. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy. There was always at least one registered nurse on all shifts in the hospital and one in the dementia unit from Monday to Friday.  The facility manager is a registered nurse and is on site five days per week. A clinical leader is also appointed to oversee clinical services and take leadership of the quality programme. |
| 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. | PA Moderate | Medicine management procedures and guidelines meet legislative and best practice requirements, however these have not been consistently implemented and an improvement is required.  The organisation uses pharmacy pre-packed packs that are checked by the RN on delivery. There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required.  Medications are stored in a safe and secure way in the treatment rooms and locked cupboards. The e-prescribing electronic system is accessed by use of individual passwords and generic facility log in.  All medication entries sampled confirmed that they are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are documented, identification photos are present and three monthly reviews are completed. The RN and care assistant were observed administering medication correctly in the dementia and hospital wings respectively. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service. An annual medication competency is completed for all staff administering medications and medication training records were sighted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. Nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents at the service. This includes the availability of snack food for residents over a 24 hour period.  The resident’s dietary profile forms are developed on admission which identifies dietary requirements, likes and dislike and reviewed as needed. Supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates were on all containers and records of temperature monitoring of food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had use by dates recorded on the containers and were current.  The residents and family/whanau interviewed indicated satisfaction with the food service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | There are documented processes that address residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau member interviewed reported satisfaction with the care and support they are receiving. Improvement is required regarding documentation and completion of all the required nursing interventions. |
| Standard 1.3.7: Planned Activities  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. | FA | The planned activities at Seadrome Home and Hospital are meaningful to the residents’ needs and abilities. The activities programme covers physical, social, recreational, spiritual, intellectual, emotional and cultural needs of the residents. The activities are modified as per capability and cognitive abilities of the residents. The occupational therapist and diversional therapist develop an activity planner which is posted on the notice boards throughout the facility. Residents’ files have a documented activity plan that reflects their preferred activities of choice. Over the course of the audit residents were observed engaging in a variety of activities. The residents and family/whanau reported general satisfaction with the level and variety of activities provided.  The process for documenting 24 care plans has been reviewed and is being implemented in a variety of ways. Care plans sampled provided sufficient information regarding the needs of the resident over the 24 hour period. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Person centred care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Family/whanau and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There have been no changes to the facility since the last audit. A current building warrant of fitness was sighted. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved fire evacuation plans. Trail evacuations are conducted as required. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance for infection rates is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. It is appropriate to the size and setting of the service. Infection rates are monitored, collated by the infection control coordinator for analysis. Infection rates are discussed during the staff, management and directors’ meetings. A running register is maintained of all infections witch is analysed by an external consultant for benchmarking purposes. Specific recommendations and interventions to reduce, manage and prevent the spread of infections is discussed in the staff meetings as well as during the daily hand-overs. The use of antibiotics is monitored and recorded. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint minimisation policy provides consistent definitions for restraints and enablers. No residents were restrained or using enablers on the day of the audit. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed are aware of the difference between a restraint and an enabler. The policies and procedures define the secure gate at the entrance to the facility as an environmental restraint. The required consents are documented. |

# 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 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Not all expired medications had been identified and remained in the medication cupboard. The controlled drug register was being checked by two RN’s when removing drugs for administration; however the checks were not being routinely conducted weekly as required. Medication records did not always include the reason for medications that had not been administered. | The medicine management system has not been implemented as required in procedure and guidelines. | Implement all areas of the medicine management system as required in procedure and guidelines.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Four out of six files identified that initial care plans and person centred care plans are completed within the required time frames while two files had no current person centred care plans developed. InterRAI assessments are completed within three weeks of admission and care plans are updated or amended as clinically indicated by a change in the resident’s condition or at least every six months whichever is earlier. | Not all long term care plans have been developed within the required timeframes. | Complete long term care plans within the required timeframes.  30 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The documented interventions for most short-term care plans and person centred care plans are sufficient to address the residents assessed needs and desired goals/outcomes. However, in three files sampled there was insufficient evidence that the required nursing interventions were being completed as required/prescribed.  For example: the care plan for one resident who was insulin dependent was adequate to manage day to day blood sugar levels, however the care plan did not provide instructions regarding the management hypoglycaemia in the event it was required (refer information regarding the hospital resident in standard 1.3.3).  In the second example: the GP had requested a weekly test which had not been completed due to resident refusal. The resident’s refusal had not been documented in the resident records. The resident was stable at the time of the audit.  The third example: includes one resident’s care plan which stated the resident should be weighed every two weeks, however this was being conducted monthly (refer dementia resident in standard 1.3.3). | There was insufficient evidence that all the required interventions have been documented or implemented as per the GP’s instructions or the care plan. | Implement nursing interventions as required/prescribed.  30 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.