# Selwyn Care Limited - Gracedale 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 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](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:** Selwyn Care Limited

**Premises audited:** Gracedale Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 September 2015 End date: 23 September 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 35

# 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

Gracedale is managed and operated by the Selwyn Foundation. The service provides rest home and hospital level of care for up to 36 residents. On the day of audit, there were 35 residents. The manager transferred from another Selwyn facility three months ago. He is a registered nurse and has had ten years aged care experience. A full-time clinical coordinator supports him.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board.  This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, general practitioner, management and staff.

The service has addressed three of three previous findings related to assessments, care plans and medication allergies.

This audit has identified no shortfalls.

## 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. |

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |

Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager and clinical coordinator are responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Strategic plans and quality goals are documented and regularly reviewed. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and robust health and safety processes. Adverse, unplanned and untoward events are responded to in an appropriate and timely manner. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An education and training programme is in place for staff. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are sufficient numbers of staff on duty to ensure residents are safe.

## 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. |  | Standards applicable to this service fully attained. |

The registered nurses complete assessments, care plans and evaluations. Residents and relatives are involved in planning and evaluating care. Care plans reviewed demonstrated service integration and were individualised to meet the resident’s needs. Care plans were evaluated six monthly or more frequently when clinically indicated. Short-term care plans are available for use for short-term needs. Residents and family interviewed were positive about the care received.   
The activities coordinator provides a five-day week programme focused on interesting and meaningful activities that meets the individual abilities and recreational preferences of the residents. Community links are maintained.

The service’s medication management system meets legislative requirements. Staff responsible for medication administration complete annual competencies and medication education. The general practitioner reviews medication charts three monthly.

Contractors prepare and cook meals on site. A dietitian has reviewed the menu. Individual and special dietary needs are accommodated.

## 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. |

A current building warrant of fitness is posted in a visible location.

## 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. |

The service has alternative systems available so that staff can use restraint as a last resort strategy. There were eight hospital level residents voluntarily using bedrails as enablers on the day of the audit. Appropriate processes are in place to ensure both enablers and restraints are used in a safe manner.

## 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 programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The service has an Infection control coordinator with defined responsibilities. Reports and surveillance data are discussed at facility meetings. Results of surveillance are acted upon, evaluated and reported to staff and relevant personnel.

## 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 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 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 | The service has a complaints policy that describes the management of the complaints process. Complaints forms are made available to residents and families. Information about complaints is provided on admission. Interviews with five residents (four hospital level and one rest home level) and family members confirmed their understanding of the complaints process. Care staff interviewed (three caregivers, two registered nurses, one activities coordinator) were able to describe the process around reporting complaints.  The complaints register includes verbal and written complaints with evidence to confirm that complaints are being managed in a timely manner, including acknowledgement, investigation, meeting time lines, corrective actions when required, and resolutions.  Nine complaints received in 2015 (year to date) were managed appropriately and within the required timeframes as determined by the Health and Disability Commissioner. Complaints are linked to the quality and risk management system. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of services provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issues arises. Two families (of hospital level residents) interviewed, stated they were kept well informed. Ten incident/accident forms were reviewed and identified that next of kin were contacted or if not, justification as to why. Residents’ meetings are held each month.  Staff are used in the first instance for interpreter services. The service can also access interpreter services through the Selwyn Foundation. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Gracedale Hospital is owned and governed by a charitable trust and is managed by the Selwyn Foundation. The facility is guided by a mission statement and associated values. Communication between the charitable trust and senior leaders from the Selwyn Foundation takes place formally every two – three months (or more frequently if issues arise). The facility manager reports that the Gracedale charitable trust board members are actively involved in operations (e.g., church services).  The facility can provide care for up to 36 residents. All 36 beds can be used for either rest home or hospital level care. During the audit there were 35 residents living at the facility, six residents at rest home level of care and twenty-nine residents at hospital level of care. There were no respite residents and no residents under the medical aspect of this contract.  An annual business plan documents five key strategies with associated tasks, measures, and responsibilities, which was developed by the Selwyn Foundation. There is evidence of six-monthly reviews of the business plan.  The facility manager is responsible for the overall management of the facility. He has been in the role since June 2015, is a registered nurse (RN) and has worked in aged care for ten years. The facility manager reports that he has resigned from his position. The clinical coordinator/RN and group residential care manager will manage the service while a replacement is sought. The clinical coordinator has been in her role at this facility for 12 years. The facility manager and clinical coordinator have maintained a minimum of eight hours of professional development activities related to managing an aged care facility. |
| 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 | Gracedale Hospital implements the Selwyn Foundation quality and risk management framework, which is linked to the organisation’s strategic plan. The facility implements organisational policies and procedures to support service delivery. All policies are scheduled for review every two – four years, depending on the nature of the policy. Policies are available to staff electronically and in hard copy and have been updated to reflect the implemented InterRAI procedures.  Service delivery is monitored through adverse events (e.g., complaints, falls, incidents, infections, unwanted events). Results are benchmarked across all Selwyn aged care facilities. Where audit results are less than the expected threshold, a corrective action process is put into place. Quality and risk results are provided to staff, evidenced in the monthly staff and monthly RN meeting minutes.  An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed and documented where opportunities for improvements are identified, with evidence of corrective actions being communicated to all staff in meeting minutes. Management signs off corrective actions when completed.  A resident satisfaction survey has recently been conducted. Results were not yet available. The previous survey results were from November 2013.  The organisation has a comprehensive risk management plan in place. The risk management plan is generated at head office and is regularly reviewed by the boards. Health and safety policies and procedures, and a health and safety plan are in place for the organisation. The facility holds a current tertiary level ACC Work Safety and Management Practice certificate. The hazard register is regularly reviewed. All identified hazards include a risk rating, controls that are in place and monitoring procedures. |
| 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 service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. The registered nurse then reviews and investigates the incidents forms. If risks are identified these are processed as hazards using a hazard identification form. Accidents and incidents are firmly embedded into quality and risk management systems.  Discussions with the facility manager and clinical coordinator confirmed their awareness of statutory requirements in relation to essential notification. This was evidenced during a recent outbreak at the facility with timeframes met. |
| 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 | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals are current. Five staff files were reviewed (two caregivers, two registered nurses, one activities officer). Evidence of signed employment contracts, job descriptions, orientation and training were available for sighting. Annual performance appraisals for staff were completed. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with care staff described the orientation programme that includes a period of supervision.  The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. Contractual requirements are being met. Staff complete competency assessments, which are linked to in-services. Four of ten registered nurses have completed their InterRAI training.  There is a minimum of one care staff with a current certificate in first aid/CPR on every shift. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The facility manager and clinical coordinator are registered nurses. Both work full-time, Monday – Friday. Six permanent staff RNs and two casual RN staff are employed. There is a registered nurse rostered on every shift covering 24 hours a day, seven days a week. A minimum of six caregivers are scheduled for the am shift and five on the pm shift with two caregivers working on the night shift.  Activities staff are onsite Monday – Friday. Volunteers and caregiver staff deliver weekend activities for residents.  Staff reported that staffing levels and the skill mix was appropriate and safe. All residents and families interviewed advised that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | All medication is managed appropriately in line with required guidelines and legislation. The RNs are responsible for the administering of medication and complete annual medication competencies. Annual medication education has been provided. All medications sighted were within the expiry dates. There were no residents self-medicating on the day of audit. The standing orders are current. Ten medication charts were sampled. Allergies were documented on the 10 medication charts reviewed. The previous finding around documentation of allergies has been addressed. GP prescribing met legislative requirements. The GP had reviewed the medication charts at least three monthly. |
| 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 | An external contractor provides all meals from within the facility main kitchen. A dietitian has reviewed the six-week rotating menu. Meals are delivered to each of the four dining areas in bain-maries and served by care staff.  The cook receives resident dietary assessments from the RN and is notified of any changes. The resident likes and dislikes are known. Alternative choices are offered for dislikes. Dietary requirements provided include soft/pureed meals, vegetarian and diabetic desserts. Cultural and religious requirements are accommodated.  The external contractor is responsible for ensuring compliance with food safety standards including food, fridge and freezer temperatures and ensuring staff have completed food handling training and chemical safety. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The service provides care for residents requiring rest home and hospital level of care. When a resident’s condition alters, the RN initiates a review and if required GP, nurse practitioner or nurse specialist consultation. Family interviewed confirm their relative’s needs are being met and they are kept informed on any changes to resident conditions. A telephone and conversation form held in the resident file evidences family notification of any health changes, GP visits and appointments.  Dressing supplies are available and a treatment room/cupboard is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use, and other management.  Caregivers, the RN and clinical coordinator interviewed stated that they have all the equipment and resources required to safely deliver care.  Wound assessments, treatment plans and evaluation progress notes were in place for three skin tears, one ankle ulcer and three grade 3 pressure areas. Specialist continence and wound care advice is available as needed and the registered nurses interviewed could describe this. |
| 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 service employs an activities officer to implement the activity programme Monday to Friday. The Selwyn village company diversional therapist oversees the activities programme in all of the Selwyn villages. A relieving activities officer from the Selwyn bureau is available to cover for leave.  The group and individual activities (one on one time), are focused on the individual abilities and preferences for both rest home and hospital level of care. Activities include newspaper reading, exercises, crafts, entertainment, outings and van drives. The van driver has a current first aid certificate. Church services are held fortnightly and there are regular pastoral visitors. Community links are maintained within the community. The library bus visits frequently.  Family input is sought to complete a resident profile and lifestyle questionnaire. Activity plans are reviewed at the same time as the care plans. Resources are readily available.  Resident meetings provide an opportunity for feedback on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluation timeframes are specified in policies and procedures. The RN evaluated initial care plans within three weeks.  Care plans reviewed were evaluated by the registered nurse and multidisciplinary team at least six-monthly or when changes to care occur for residents. Resident/family/whānau are invited to provide input into the care plan review. Short-term care plans were in use for short-term needs and evaluated within a timely manner. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility has a current building warrant of fitness, which expires on 30 March 2016. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections and definition of infections. The infection control coordinator (RN) uses the information obtained through surveillance to plan and determine infection control activities, resources and education needs within the facility. An infection report form and short-term care plan is completed for the management of a suspected/diagnosed infection.  All infections are entered onto a monthly infection analysis form. Trends (monthly and yearly comparisons) and quality improvements are identified and monitored. Corrective actions are developed when needed and implemented. The IC coordinator and GP monitor antibiotic use. The surveillance of infection data assists in evaluating compliance with infection prevention and control practices. The data has been monitored and evaluated monthly and annually at facility and organisational level.  Staff interviewed confirmed they are kept informed on infection rates, trends, corrective actions and quality initiatives relating to infection control activities.  The facility experienced a respiratory infection outbreak in August 2015. A case log and outbreak management notes were maintained. Relevant personnel were notified. There were adequate supplies of personal protective equipment available. A staff debrief identified the outbreak was well managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint coordinator position has been delegated to a registered nurse. She has a clear understanding of her role. The use of restraint is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There were eight residents with enablers in the form of bed rails in the hospital. The residents requested these with consent signed by either the resident or their enduring power of attorney (EPOA). Two residents using enablers with consent provided by the EPOA were interviewed, which confirmed that the use of the enablers (bed rails) were voluntary.  Two residents’ files were reviewed which confirmed implementation of the assessment, consent, review and monitoring processes. Enabler use is reviewed each month and is linked to the residents’ care plans. There was one hospital level resident using restraint. |

# 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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| No data to display |

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

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

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

If, instead of a table, 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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| No data to display |

End of the report.