Seadrome Limited - Seadrome Home & Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	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: 26 November 2015 End date: 27 November 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: 45

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

This re-certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. Seadrome Home and Hospital provides dementia and hospital level care for up to 45 residents. There have been no significant changes to the facility or services since the last certification audit.

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.

Management and staff have implemented a range of quality projects resulting in improved outcomes for residents and a continuous improvement rating. In addition, there are three low risk areas which require corrective actions to order to achieve full compliance with this standard.

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.

Staff are able to demonstrate an understanding of residents' rights. This knowledge is incorporated into their daily work duties. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. Continuous improvement ratings have been allocated regarding a quality project which was implemented to address cultural needs and improve engagement with residents experiencing dementia.

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

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.		Some standards applicable to this service partially attained and of low risk.

The organisation is governed by the directors/owners. Day to day operations are the responsibility of an experienced facility manager, and an assistant 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 implemented to improve resident outcomes. The required policies and procedures are documented, reviewed and controlled. Quality related data is communicated and improvements made when required.

All staff are suitably trained. Competencies are assessed and performance is monitored.

Resident records are integrated and maintained in a secure manner. Entries in records meet best practice standards for the management of health records.

Three corrective actions are required. These include improvements with recording collated quality data and family notifications and better maintenance of staff records.

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.

Residents receive timely, competent and appropriate services that meet their assessed needs and desired outcome/goals. The residents are admitted with the use of standardised risk assessment tools. Short term care plans are consistently developed and evaluated when acute conditions are identified. The long term care plans are reviewed every six months. Planned activities are appropriate to the needs, age and culture of the residents.

The medicine management system meets the required regulations and guidelines. There are no expired or unwanted medications. The controlled drugs register is correct and current.

Meal services meet the individual food, fluids and nutritional needs of the residents.

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.

All building and plant comply with legislation with a current building warrant of fitness in place. Equipment and electrical checks are conducted. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The dementia area is secure with large, safe areas for residents to wander.

Cleaning and laundry services are of an acceptable level. These services are monitored to ensure they continue to meet the needs of the residents.

Essential emergency and security systems are in place. There is an approved fire evacuation plan and emergency drills are conducted as required. Call bells allow residents to access help when needed.

Restraint minimisation and safe practice

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

There are clear and comprehensive policies and procedures that meet the requirements of the restraint minimisation and safe practice. There are no residents using restraints or enablers. The secure gate at the entrance to the grounds has been approved and meets the requirements for environmental restraint. There is a current restraint register. Staff demonstrated good knowledge regarding restraints.

Infection prevention and control

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

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The type of surveillance is appropriate to the size and complexity of the service. Infection rate data is collected, recorded, analysed and reported. Recommendations to reduce the infection rates are discussed during staff meetings. The clinical and quality initiative team is responsible in implementing and evaluating the infection prevention and control programme.

The infection control nurse has adequate knowledge regarding infection prevention and control.

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	2	44	1	2	0	0	0
Criteria	4	94	1	2	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	Documented policies reflect the intent of the Code of Health and Disability Services Consumer Rights (The Code). The Code is included in the orientation of all new staff. Training related to various elements of The Code is provided in an ongoing manner. This training is provided by a national advocacy service representative and includes the Code, open disclosure, complaints, informed consent, dignity and respect, advanced directives and abuse and neglect. Staff, residents and relatives interviewed, and observation during the audit, indicated that staff understand resident rights and their responsibilities and that residents rights are observed in practice.
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 informed consent policy is in accord with the Right seven (7) of the Code. Situations where general written consent is required are defined and include outings, photos, treatments, and sharing of information with other health professionals. The required consents were sighted in records. These have been signed by the residents' next of kin. A system for advanced directives is defined and maintained in compliance with regulatory requirements. All relatives/family are given information on advance directives which allows

		for the identification of competency and resuscitation status. Enduring Power of Attorney orders are in place for those residents who need them.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff training on the right to advocacy / support is provided annually.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	There is an open visiting policy in place. Visitors were observed to be made welcome. Interviews with residents and family members and observation during the audit confirmed that they may freely receive visitors and may entertain their visitors in the lounge in each area or one of small alternative sitting areas, also in the privacy of their own rooms. There is evidence that links with community resources are supported and facilitated. Families are encouraged to take their family member out if physically able. Suitable residents are taken on trips into the local community in the facility van. Arrangements for attendance at specialist appointments are facilitated by staff as required
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 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. Verbal complaints and concerns expressed to staff are written in a register in each area. 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 1.1.2: Consumer Rights During Service Delivery	FA	Documented procedures and interviews with residents, family and staff confirmed that residents' rights are understood and met in everyday practice. Information about the Code

Consumers are informed of their rights.		of Rights, advocacy services and the complaints process is provided on admission and displayed in the entry foyer. The Code is displayed in Maori and English. Residents and families interviewed were aware of their rights and confirmed that information was provided to them during the admission process. Signed resident agreements were sighted in records sampled. These have been signed by the next of kin.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are documented procedures to ensure residents are provided with services that support their independence (where applicable) and maintain their privacy and dignity. A review of care plans confirmed that personal and privacy needs are considered. Residents' visual and auditory privacy is respected. The majority of residents have private rooms. There are three shared rooms, with privacy curtains between beds. Consent to share rooms is obtained from the family. The majority of rooms contain personal belongings and family interviewed stated the belongings are respected. Each bedroom door has the name of resident and a picture which provides meaningful insight into the person. Interviews and observations confirmed that Seadrome is committed to ensuring residents are not subjected to abuse or neglect. The different types of abuse and neglect are defined within policies and guidelines. Reporting requirements, management of investigations, and follow up activities are also defined. Management responds to all concerns in an appropriate and timely manner. Family members interviewed stated they feel their family member is safe and treated with dignity and respect at all times. Values and beliefs are respected. The organisation demonstrates continuous improvement regarding Maori health gains and cultural activities (refer standard 1.1.4 and 1.1.6). Fortnightly church services are held and a staff member provides regular prayer and bible readings to residents (if requested). Public festivals and holidays are observed and celebrated.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	CI	A Maori Health Plan is documented. This addresses barriers to access for Maori residents and whanau. Cultural needs are identified in the 24 hour activity plans and in long term care plans. There is access to cultural advice, resources and documented protocols to ensure recognition of Maori values and beliefs for residents who identify as Maori. Cultural safety training is provided to all staff and cultural activities are observed and practiced. The facility manager is learning Te Reo and a number of staff can converse with Maori residents using Te Reo.

		A planned improvement project has been implemented and reviewed resulting in improved outcomes for Maori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	CI	The outcomes from a quality project have been further implemented to ensure all residents benefit from cultural acknowledgement and inclusion. Cultural needs are identified and respected.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Policies define processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation with specific reference to the needs of residents with dementia. Staff have a criminal record check and reference checks prior to employment. Staff receive information and education during orientation and on-going education about professional boundaries and non-discriminatory attitudes. Interviews with residents and family, and observation during the audit, indicated that residents are free of any form of coercion or discrimination. In interview, the general practitioner (GP) confirmed the provision of consistent and respectful care to all residents.
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, residents and families confirmed that communication is conducted in an open manner. Resident meetings occur and the facility manager has an open-door policy. Resident and family surveys are conducted and any issues raised are followed up and remedied promptly. Family members interviewed stated they have the opportunity to talk to management or staff and are able to request changes if needed. Family members also stated that they 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 against the strategic plan. The facility manager meets with one of the directors on a weekly basis. Meeting minutes

		confirmed management reports on organisation performance and achievement towards the strategic goals. The facility manager is a registered nurse and has been in the position for 25 years. The facility manager has previous experience in the care of aged and dementia and maintains training hours in management and nursing scope of practice.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The assistant manager fulfils the role of the facility manager during a temporary absence. The assistant manager is a registered nurse with previous experience in managing an aged care facility. The assistant manager has been working at Seadrome for 18 years. The facility manager and assistant manager conduct weekly management meetings. The management team is also supported by a part time quality nurse/coordinator and the administrator.
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.	PA Negligible	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. An improvement is required to ensure all quality related data is collated and analysed for trends. There was evidence of communication with staff and management at quality (CQI) and staff meetings. Staff are informed of quality improvements and corrective action plans. A risk management programme in place. This includes Health and Safety policies and a health and safety plan. There is a hazard/risk management programme with a hazard register updated if new hazards are identified. Business, clinical and financial risk are monitored.
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	PA Low	The 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 and missing persons. 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

choice in an open manner.		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, however there was inconsistent evidence that family had always been contacted, or the manager informed.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	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 all staff have a 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 monthly, as per the training plan. Education and training hours exceeded 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. An improvement is required with regard to records management of staff files.
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 staffing policy is the foundation for work force planning. 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 and assistant manager (both registered nurses) work full-time. A clinical/quality nurse is also appointed to take leadership of the quality programme and InterRAI. Residents and families interviewed confirmed staffing was adequate to meet the residents'

		needs.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The admission process provides verification and documentation of individual resident information. Daily resident lists are maintained. Access to electronic records is guarded by individual password. Electronic data is backed up nightly and held securely off site. Resident files are stored securely in the nurses' station in both the dementia unit and hospital area. Review of resident records indicated they include reports from all health professionals. Daily progress notes are maintained and records are integrated in the one file. Entries are legible, dated, signed and designated. A specimen signature list is maintained. The registered nurse interviewed stated that in the event of transfer to hospital the relevant data accompanies the resident. This includes the residents' health passport. Archived records are stored securely and maintained for 10 years at which point they go into the secure document destruction bin.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to the service policy was sighted which include requirements and procedures to be followed when a resident is admitted to the service. Admission agreements are sighted in all resident's sampled records. Residents and families reported that the admission agreements were discussed with them in detail by the manager, assistant manager or charge nurses. All residents have the appropriate needs assessments prior to admission to the service. A pamphlet containing information about the service was sighted. The manager ensures that residents are admitted to the service as per contractual requirements. All enquiries are recorded in the enquiry register.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	A standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or to another service. The yellow envelope is utilised with the transfer notification form. The assistant manager confirmed that telephone handovers are conducted for all transfers to other services. Residents and their families are involved for all exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and	FA	A medicine management system is consistently implemented to ensure that the residents receive medicines in a safe and timely manner. Medication charts are generated by the

timely manner that complies with current legislative requirements and safe practice guidelines.		pharmacy and photos are present in all reviewed medication charts. There is evidence that medication charts are reviewed regularly. All discontinued medications are signed and dated by the GP and allergies are well-documented. Medicine reconciliation is conducted by the RNs when a resident is discharged back to the service. Staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medication rounds in the hospital and dementia units. Current medication competencies are evidenced in the staff files. The system in place for the management of medicine meets the required regulations and guidelines. The controlled drugs register was correct and current and weekly stocktake is conducted by the RNs regularly. There are no residents who self-administer medications. Self-administration policies and procedures are in place. All medications are stored appropriately.
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	Food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked onsite by the cooks. There was evidence of current food handling certificates. Residents are provided with meals that meet their food, fluids and nutritional needs. The RNs complete the dietary requirement forms on admission and provided a copy to the kitchen. The kitchen board is updated regularly. Additional or modified foods are also provided by the service. Fridge and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen to the dementia unit dining area and the food for the hospital unit is transported in a bain marie. Meals are well-presented and residents confirmed that they are provided with alternative meals as per request. All residents are weighed regularly. Residents with weigh loss problems are provided with food supplements.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the	FA	There is a documented policy on decline of entry to the service. When a resident’s entry to the service is declined, the resident is referred back to the referrer to ensure that the resident is admitted to the appropriate level of care provider. These are evidenced in the decline of entry to the service register. The assistant manager reported that the district health board needs assessors and social workers contact the manager to discuss the

organisation, where appropriate.		suitability of the resident prior to sending the resident's family to view the facility. When there are no vacant beds, the person's name is entered in the waiting list and contacted by the manager when vacant beds are available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The registered nurses (RNs) utilise standardised risk assessment tools on admission and these assessment information are the basis in developing the resident's initial plan of care and the long term care plans. New residents are admitted using the InterRAI assessment tool and the outcome scores are used as the focus of their long term care plans. There are evidences that assessments are conducted within the specified timeframes.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long term care plans are resident-focused and personalised. There was evidence that continuity of service delivery are promoted. Goals are specific and measurable while the interventions were sufficiently detailed to address the desired goals/outcomes identified during the assessment process. Long term care plans are reviewed and updated in a timely manner. The RNs develop short term care plans for all acute conditions. Residents and families are involved in the development of long term care plans. Staff members are informed about changes in the care plans through the hand overs and monthly meetings.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documented interventions are sufficiently detailed and well-documented to address the assessed needs and desired goals/outcomes. Interventions in managing acute infections were documented in the short term care plans. Interventions are updated when the desired goals/outcomes are not met or when the resident's response to the treatment is not satisfactory.
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	Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The activities coordinator develops the weekly activity plans with the manager, charge nurses and with the residents when able. The weekly activities are posted in the nurse's station of the dementia and hospital units and in their respective lounges. Activity plans are well-documented and reflected the resident's preferred activities and interests. The resident's activities participation log was sighted. Interviewed residents and families verbalised the activities provided by the service are adequate and enjoyable. A 24-hour activity plan is in place for all residents in the

		dementia unit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Short term care plans are evaluated by the registered nurses and the resolution of the identified acute conditions documented in the reviewed resident's files. Long term care plans were reviewed and evaluated every six months or earlier as required. Interventions in both long term and short term care plans are modified when the outcomes are different from expected. In interview, residents and family members reported they were involved in all aspects of care and reviews/evaluations.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. Residents and the families are kept informed of the referrals made by the service. Internal referrals are facilitated by the manager, assistant manager or by the charge nurses.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented processes for handling waste and hazardous substances. Processes for the collection, storage and disposal of biomedical waste, household rubbish and recyclables are in accord with infection control principles and comply with local body requirements. Cleaning staff have received training in the handling of chemicals and hazardous waste. Chemicals are delivered by an external provider. Chemicals are accessed through a closed chemical dispensing system. Secure storage is provided. Safety data sheets are available in the laundry and cleaner's room. Personal protective equipment is provided and observed to be used by staff. Minutes of monthly quality meetings confirmed that any issues related to chemicals or waste are reviewed and promptly resolved. General waste management audits are routinely conducted.
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 is a planned maintenance programme and the building is well maintained. There is a monthly maintenance inspection checklist with evidence that maintenance concerns are identified and followed up in a timely manner Furnishings, fittings and floorings are well maintained and suitable for the care and support of residents. Applicable building

		regulations and requirements are met. There is a current building warrant of fitness. Large, well-furnished lounge and dining areas are provided. Handrails are in all corridors. Ramps have non slip floor covering and a handrail. There is sufficient space for the use and storage of mobility aids. Sufficient equipment and supplies are available. The hoists and weighing scales are functionally maintained. Medical equipment is calibrated annually. Electrical equipment is tested. Residents are transported to external appointments and events in a van with current registration and warrant of fitness. Enclosed gardens and safe, sheltered external areas with suitable seating is available. Mobile residents are protected from traffic on the driveway by a key coded gate with a further key coded gate at the exit on to the road. There are paved pathways for residents to walk in the grounds and there is ample safe areas outside for residents to wander.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are sufficient individual toilets and bathrooms provided. Some bedrooms have ensuites. Bathrooms are well lit, fitted with hand rails, non-slip flooring, and call bells. Finishing materials are waterproof. Reversible door catches and privacy curtains are installed in each bathroom. Hot water is monitored routinely, where a variation occurs this is followed up. All staff carry hand gel and there is a hand basin in each room.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are sufficient bedrooms to accommodate 25 residents in the rest home/dementia area and 20 residents in the hospital. There are three shared rooms in the dementia area. This has been approved by family members. Rooms used for hospital residents are of sufficient size to accommodate residents requiring hospital level care, allowing for mobility aids, equipment and staff caring for the resident. Electric beds are provided for hospital residents. There is adequate room in all bedrooms for personal possessions. Each bed space is provided with a wall light and a nurse call bell. Residents and relatives interviewed confirmed that their bedrooms were adequate for their needs and their personal space is respected.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	There are separate well-furnished lounges and dining areas for the hospital and the dementia area. Activities are provided in the lounge areas and in a separate recreation room. Alternative additional small sitting areas are available in each area. The communal

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		areas are sufficient to accommodate all the residents. There is a variety of seating to suit all needs. There is room to accommodate wheelchairs and walkers. Residents and relatives interviewed confirmed that the lounges and dining areas meet their needs. Surveys provide residents/family with the opportunity to provide feedback regarding the facility.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry services are provided on site in an area that is fit for purpose. The laundry room has good separation of clean and dirty areas and laundry processes meet good practice guidelines. Maintenance, functional testing and temperature records sighted indicate the laundry processes meet infection control standards. Interviews with staff, residents and family indicate satisfaction with facility cleanliness and the state of linen and personal clothing. Cleaning services are provided by employed staff. Interview with one of the cleaners, review of internal audit records and visual inspection indicate that cleaning meets infection control requirements and is of a high standard. A well-equipped cleaning trolley with secure storage for chemical containers and a secure cleaning room is provided. The cleaners are trained in the use of equipment and chemicals. Documented material safety data sheets are available in work areas. Management monitors cleanliness and laundry standards through observations, resident/family feedback and internal audits.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is a current approved evacuation scheme. There is evidence in training records that fire and evacuation training has been provided twice in the last 12 months and all staff have attended at least once. There is a pandemic response plan and sufficient supplies in the event of a civil defence emergency. All staff are trained in emergencies and have a current first aid certificate. All bed spaces, bathrooms and toilets have a nurse call bell. These were seen to be within easy reach of the resident. The location of the call shows on electronic light boards in the rest home nurses' station and the lounge and corridor in the hospital. Functional checks are done monthly. There are emergency call bells in the dementia area. A suitable security policy and lock down process is in place. The entire grounds are secure with key pad entry.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility has plenty of natural light. All bedrooms have at least one good sized window that opens and some have doors to the garden. There is plenty of natural ventilation. The hospital wing has under floor heating with thermostat controls in each bedroom. There are wall mounted electric panel heaters in communal rooms, corridors and bedrooms in the dementia area. Observations during the audit and interview with residents and family members indicated that the internal environment is maintained at a comfortable temperature. A small sheltered area away from the main building available for residents who smoke.
Standard 3.1: Infection control management 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.	FA	The responsibilities for infection control are clearly defined. One of the charge nurses (CN) is the delegated infection control nurse who is responsible for collecting infection control data. The service utilised the support of the district health board infection control experts and gerontology nurse specialist. The infection control programme is reviewed annually. The clinical and quality initiative team is also the infection control committee. Infection prevention and control is included in the staff meeting agenda. The infectious diseases prevention policy is in place to prevent visitors suffering from, or exposed to and susceptible to, from exposing others while still infectious. Resident's families and relatives are encouraged not to visit when they are unwell. There are hand sanitizers in the nurse's station and there are adequate hand basins for the residents and staff to use. In interview, staff confirmed that infections are included in the hand-overs and staff meetings. Infection control policies and procedures are readily available for the staff in both nurse's station.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control nurse is responsible for facilitating infection prevention and control activities in the facility. The clinical and quality initiative team is also the infection control committee who is responsible in implementing and evaluating the infection control programme of the service. The GP reported that the RNs contact the medical centre when residents manifest suspected infections. The district health board nurse specialists provide expert advice regarding infection control. The interviewed staff were knowledgeable regarding outbreak management and breaking the chain of infection.

Standard 3.3: Policies and procedures 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.	FA	There are documented policies and procedures for the prevention and control of infection. Policies aligned with current accepted good practice and relevant legislative requirements. Policies are readily available and procedures are practical, safe and suitable for the type of service provided. The service consistently implemented the policies and procedures. The service has a hand hygiene auditor who ensures that staff regularly practice proper hand washing. Staff have demonstrated good knowledge on infection control prevention and control.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control and prevention education is provided to staff as a component of their ongoing education programme. Infection control in-service education is conducted regularly. Residents and families are provided with advice on infection prevention and control activities. In interview, staff demonstrated good knowledge in infection prevention and control measures. The infection control nurse demonstrated good knowledge of current practice in infection prevention and control as well as outbreak management.
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 and management meetings. 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 service demonstrates that the use of restraints is actively minimised. Seadrome is a dementia specific facility. Residents have moderate to advanced dementia and are subsequently unable to differentiate between restraint and an enabler due to their cognitive impairment. There are no residents using a restraint or enabler. Policies and procedures provide accurate definitions of restraints and enablers. Policies define the secure gate at the entrance to the facility as an environmental restraint. There are

		also guidelines on the management of behaviours of concern. In interview, staff demonstrated a good knowledge of restraint minimisation.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	There is a restraint approval process, should an individual restraint be required. The use of the security gate at the entrance to the hospital grounds has been approved. The intent of the secure electronic gate is for the residents' safety and wellbeing. The code to enter and exit the grounds to the hospital is displayed next to the keypad on both sides of the gate.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A psychogeriatrician or geriatrician assesses all residents prior to their admission. The assessment states that the resident requires specialist dementia services. Seadrome only accepts people with a diagnosis of dementia for admission in both the dementia unit and the hospital. The required consent forms regarding the security gate have been signed by the resident's representative.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	There are no individual restraints in use. The use of the secure gate has been approved and is considered appropriate to the setting and needs of the residents. The restraint register is current.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Individualised person centred care plans assess and support the delivery of care and avoid the use of restraint. Care plans are reviewed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	There have been no adverse events, or complaints regarding the secure gate at the entrance to the facility. The restraint minimisation policy is current and clearly describes the process and intent of the locked gate.

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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Negligible	All quality activities are discussed at CQI and staff meetings. These provide quantitative data on the number of incidents, accidents, complaints, infections and progress towards achieving quality goals. Although the numbers are recorded there is insufficient documented evidence that discussions include an analysis of the information.	There is insufficient documented evidence that all quality related data is collated and analysed.	Maintain evidence that quality related data is collated and analysed. 180 days
Criterion 1.2.4.2 The service provider understands their	PA Low	The organisations internal process requires staff to notify family members when an incident occurs. This was required to be documented in the incident report and an entry in the progress noted made. A range of incident records, and progress notes were sampled. Notifications to the family, and in one case	There is inconsistent evidence that notifications to	Maintain evidence of family notifications,

statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.		the manager, had not been consistently documented.	family members (and management) are always made as required.	and reports the manager, following an incident 180 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Sampling identified a number of gaps in the staff records. Eight (8) staff records were sampled, including three recently appointed staff. Evidence of orientation was not available in two records, records of police checks and references had not been consistently filed and current job descriptions were evident in four of the eight. The assistant manager and diversional therapist job descriptions were also not available. Although staff and management confirmed that these processes had been completed, the records could not be found.	Not all records pertaining to human resources were accessible.	Maintain staff records in a manner that ensures consistent accessibility. 180 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.	CI	In 2013 management commenced a quality project with the aim to improve services provided to Maori residents. Although there were a range of processes in place to improve services for Maori, management felt that more could be done to improve access and engagement. Project Toru was implemented throughout 2014. The project was supported by the local gerontology nurse and district health board. The organisation engaged with the community and approached a local school. School students from the cultural group commenced weekly visits to the facility. Each student worked one on one with a Maori resident. The project was monitored and evaluated. Qualitative data was obtained and demonstrated improved outcomes for Maori residents. This was evident in records of care plans and reviews. The residents became more engaged in their surroundings and activities. There was evidence of improved self-esteem and personal awareness. The project successfully increased the amount of Maori visitors, including local Iwi representatives and whaia.	Project Toru has effectively eliminated barriers to access. Data sampled confirmed that the project has improved the outcomes for Maori residents.

Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.	CI	Project Toru was completed at the end of 2014. The project was successful in demonstrating improved Maori health gains. Due to its success the organisation decided to continue and extend the project. Following a full review of all the activities a new steering group was formed. The steering group terms of reference was developed. A new model of care and philosophy were adopted. The model identified key activities which are now being fully implemented. These activities include whakapapa, poi's, weaving, storytelling, waiata, karakia and powhiri. Engagement from Maori residents has continued to improve with some residents demonstrating behaviours consistent with those of seen on the marae.	Implementation and review of Project Toru provides on-going evidence of improved engagement and outcomes for Maori residents.
Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.	CI	All staff are fully engaged with the revised philosophy and model of practice. A number of staff are on the steering group and Te Reo is being more consistently used when communicating with residents. Meeting minutes from the steering group confirm continual evaluation of the project. Initiatives continue to develop with the next steps already identified. The project plan is to further engage in the community. In interview, the facility manager advised that staff have developed a greater understanding of dementia and the value of cultural identity for residents with dementia. Family have been actively involved throughout. The whanau approach gained momentum throughout the facility with added value is now evident with the non-Maori residents as well.	On-going staff activities demonstrate how the acknowledgment of whanau and the concept of 'turangawaewae' continues to improve involvement with Maori residents and their whanau.
Criterion 1.1.6.2 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	CI	Full implementation of project Toru has resulted in improved outcomes for all residents. The model of practice has resulted in a more comprehensive approach to cultural diversity and aided in increased awareness of identity when working with residents who have dementia.	The quality project regarding cultural awareness and identity has improved engagement and communication with all residents. Behaviours which could be classed as a possible behaviour of concern are viewed and managed as an expression of cultural needs. This has resulted in better staff understanding and improved outcomes for residents.

beliefs.			

End of the report.