

Capella House Limited - Capella House

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:	Capella House Limited
Premises audited:	Capella House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 August 2016 End date: 30 August 2016
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:	27

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Capella House provides rest home, hospital and secure dementia care services to up to 29 residents. The dementia service is separated into two wings, with one focusing on males only and the other a mix of genders. There were 27 residents at the time of audit, with seven of these resident's younger people under the age of 65 (three in the rest home and four in the two dementia units).

The service has a strong focus on person directed care and service provision. Positive feedback was received regarding the quality of the care provided and the homelike nature of the service. The strengths of the service include the focus on meaningful activities, especially in the dementia units.

This certification audit was conducted against the relevant Health and Disability Services Standards and the services' contract with the district health board. The audit process included an offsite review of documentation and onsite audit to evaluate that the service meets each of the relevant standards. Interviews were conducted with the owner, management, clinical and non-clinical staff, residents, family/whanau and general practitioners.

There were two required improvements identified at this audit. These relate to ensuring contractual timeframes are met with assessment/re-assessment documentation and ensuring that complaints documentation is fully completed.

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.		Some standards applicable to this service partially attained and of low risk.
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Staff demonstrate knowledge and understanding of how to implement the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) into service delivery. Residents and their family/whānau are informed of their rights at admission and throughout their stay. There are copies of the Code of Rights posters, brochures and information relating to the Nationwide Health and Disability Advocacy Service available in the residents packs and displayed throughout the service. The Code is available in English and Maori.

Residents and family/whānau receive services that respect their dignity, privacy, independence and cultural values.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. The service has links with community health services to meet the needs of the resident population. Residents have access to the visitors of their choice.

Informed consent and open disclosure requirements are evident. Interpreting services are contacted when required. The complaints process meets the requirements of the Code and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The owner/director ensures that business and strategic planning is in place to cover all aspects of service delivery. The annual business plan is personalised to the services offered and strategic goals reflect organisational planning outcomes. The facility manager is responsible for the overall management of the service. The facility manager is supported by the clinical nurse manager and senior members of the organisational team. The facility manager is suitably experienced.

Policies are reviewed at organisational level and reflect current legislation and best practice. Quality and risk performance is reported through meetings and quarterly analysis. Quality and risk management activities and results are shared with management, staff, residents and family/whānau, as appropriate. Monitoring and review of service delivery includes incidents/accidents, infections, complaints, restraint and reports from the internal audit programme. Any accidents or incidents are managed effectively, with actions implemented to minimise the reoccurrence of adverse events.

There are appropriate processes in place for the recruitment, employment, orientation and ongoing education of staff. The education provided covers aged care requirements and specific education and training related to dementia specific care and services. There are adequate staff numbers and an appropriate skill mix each shift to meet the resident's needs.

Record management meets the requirements of the standards. There is no resident information that is accessible to public

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.		Some standards applicable to this service partially attained and of low risk.
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There are appropriate processes in place for entry to the service. Prospective residents require a needs assessment for rest home, hospital or specialist secure dementia care. If entry is declined, the referrer is informed of the reason why.

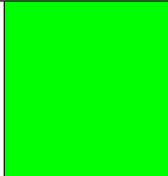
The assessment, planning, interventions and review of service delivery is undertaken by suitably qualified and experienced staff to meet the needs of the residents at the various levels of care. Individualised care plans are based on the residents assessed needs and routines. The resident and where appropriate their family/whānau are involved in the development and review of the care plans. Care plan interventions are appropriate and reviewed and evaluated on a regular basis.

The planned activities are individualised for each resident to ensure they participate in meaningful activities. There are specific programmes to meet the needs of the younger residents, the residents living in the dementia unit, as well as the residents in the rest home hospital section. Residents assist with household duties, facility and grounds up keep and care of the animals if this is what they wish to do. There are strong links with community activities and maintaining relationships with family/whanau.

Safe medication procedures were observed. Staff who assist in medication management are assessed as competent to perform their role. Where possible the service encourages residents to self-administer their own medications.

The menu has been reviewed by a dietitian as suitable for younger and older people living in long term care. The residents living in the dementia units have access to nutritional snack 24 hours a day.

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.
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There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances, and to provide safe and hygienic cleaning and laundry services. Cleaning and laundry processes are appropriate to the setting and staff are guided by policies and procedures to ensure residents are provided with a safe and hygienic facility.

All building and plant complies with legislation with a current building warrant of fitness displayed. The service has an approved fire evacuation plan. Ongoing maintenance ensures the building is maintained to meet the needs of the residents.

There is adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas meet residents' relaxation, activity and dining needs. Bedrooms are single occupancy. Outdoor areas provide suitable furnishings and shade for residents' use. Residents and families/whānau interviewed were happy with the environment provided.

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.
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The service has a commitment to the minimising and appropriate use of restraint/enablers. Restraint and enablers are only used as a last resort to maintain the resident's safety and comfort. Clear definitions in the policies reviewed ensure staff understand the implication of restraint and enabler use. There were no restraints in use and some residents using a bed loop that are assessed as enablers.

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.
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The infection prevention and control programme and policies and procedures reflect current accepted good practice. The programme is reviewed at least annually. The programme is implemented to reduce the risk of infections occurring and prevent

cross contamination of infections to staff, residents and visitors. Infection control education is provided to staff and where appropriate residents and family/whanau.

There is a monthly infection surveillance programme, which records and analyses the monthly data. The surveillance results are communicated to staff and management through fortnightly and monthly meetings.

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	0	43	0	2	0	0	0
Criteria	0	89	0	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	Staff verbalised knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the Code is included in staff orientation and in the annual in-service education programme. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents. The residents and family/whanau reported that staff act respectfully at all times.
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	General consents were sighted in resident files sampled. These were signed by the resident or their next of kin/enduring power of attorney (EPOA). It is recorded in the resident's file if the EPOA has been activated. There are specific consent forms for other medical procedures such as vaccinations. Staff acknowledged the resident's right to make informed choices and respecting any end of life wishes. Residents and family/whānau expressed no concerns related to informed consent.
Standard 1.1.11: Advocacy And Support	FA	Residents and family/whanau are informed of their rights to advocacy services and how to access them. Advocacy information including contact details is included in resident admission

<p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>packs and is on display at the facility.</p> <p>Residents and family/whanau reported they know their rights related to engaging an advocate and where to obtain the information.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours which encourages friends and family/whanau to visit. Residents are encouraged to maintain community links such as special interest groups or local clubs. The service has links with religious, marae and community activity services.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The service has complaints forms on display at the entrance to the facility. Staff report that they document all complaints and that the facility manager follows them up to completion. The complaints register is up to date and shows the nature of the complaint, the date received and the date the complaint was resolved, however the actions taken to resolve or address the complaint is not consistently well documented.</p> <p>It is reported that there have been no complaints reported to external agencies.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code is explained to residents during the admission process and is discussed at resident meetings. Resident understanding of the Code is reviewed as part of the resident satisfaction survey. The Code is displayed throughout the facility in English and Maori. If further clarification is required, this is actioned by staff.</p> <p>Information related to the National Health and Disability Advocacy service is included in resident entry packs and brochures are available at the entrance to the facility.</p> <p>Residents and family/whanau interviewed reported that their rights are respected and that they understand their right to the advocacy services of their choice.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and</p>	FA	<p>As per policy staff ensure residents privacy is maintained. This was observed on the days of audit. Residents bedrooms are single occupancy. Staff report knowledge of residents' rights and understand dignity and respect.</p> <p>Residents individual beliefs and values are captured in care planning and service delivery. Service delivery is individualised for each resident to allow independence and care delivery</p>

independence.		<p>which meets their needs. This was confirmed during resident and family/whanau interviews.</p> <p>The residents and family/whanau did not express any concerns regarding abuse, neglect, discrimination or their privacy being breached. All residents spoke highly of the manner in which the staff interact with them. Staff confirmed during interview that they would report any concerns they may have related to abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are no known barriers to access to the service for residents who identify as Maori. Staff are guided by policy which reflects the concepts and values of Te Whare Tapa Wha. Policy and Maori Health plan identifies how the service meets their understanding of the Treaty of Waitangi. Documentation identified available Maori advocates and Pacific Island advisors.</p> <p>At the time of audit there was one resident of Maori descent. Resident individual cultural values and beliefs are identified in the care plan. Staff verbalised and demonstrated knowledge of individual resident and family/whanau values and beliefs and how they are respected.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care plans identify resident's individual values and beliefs including culture, religion and sexual gender identity. All files evidenced that care was developed in consultation with the resident, and where relevant, the family/whanau. During interview, residents and family/whanau reported that the service meets their individual needs.</p> <p>Staff demonstrated knowledge in respecting and meeting the individual cultural needs, values and beliefs of each of the residents. For example, ethnic festivals are celebrated and residents attend church services of their choice. There are residents and staff of matching cultural backgrounds and shared language at the service.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Individual employment contracts, house rules and policies have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and family/whanau reported they have no concerns about discrimination. Staff verbalised their knowledge and understanding of actions to take should they be concerned about acts of discrimination.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Policies and procedures are linked to evidence-based practice and there are a number of resources available from specialists, such as wound management and behaviours of concern. There are regular visits by the GP and links with other health providers such as, community mental health providers and palliative care services.</p> <p>There is access to external education that is focused on aged care and best practice. The in-service and external education provided covers the contractual requirements and specific needs of the resident group. Staff reported and were observed promoting good practice especially in relation to the management of behaviours of concern.</p> <p>The residents and family/whanau expressed satisfaction with the supports and services provided at Capella House.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service promotes an environment that optimises communication as identified in the open disclosure policy and procedure. The facility manager stated that interpreter services are accessed as and when required. Staff reported that they are able to communicate effectively with residents who do not have English as their first language.</p> <p>Documentation of open disclosure following incidents/accidents is evident and confirmed during resident and family/whanau interviews. The monthly residents meeting provides an opportunity for bringing up any issues.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service has a maximum capacity of 29 residents. On the day of audit 27 beds were occupied consisting of one rest home, eight hospital and 18 dementia care residents. Seven residents were under the age of 65 years. (Four in the dementia care unit and three from the rest home/hospital facility). The younger people living in the dementia unit have all been assessed as requiring dementia level of care. One wing of the dementia unit specialising in males with dementia includes three of the younger residents.</p> <p>The organisation has a business plan which identifies the mission statement, vision and philosophy and shows the organisation's planning process. The services are managed to recognise and meet the needs of a range of ages, gender mix, physical and cognitive needs of the residents.</p> <p>Strategic planning is undertaken annually to ensure that services meet the needs of the residents. This is reflected in the business plan goals and objectives sighted which covers all aspects of service delivery. There are formal management meetings every two monthly to</p>

		<p>review progress with the set goals, with more informal communications with the owner/general manager at least weekly.</p> <p>The facility manager holds appropriate qualifications and has many year experience in aged care and is responsible for the overall service delivery. The facility manager is supported by an experienced clinical nurse manager who leads the clinical team. The facility manager is also supported by one of the owners who is a registered nurse and owns another two facilities. The senior management team attend appropriate education to maintain current knowledge and skills.</p> <p>The staff and resident and family/whanau reported that both the facility manager and clinical nurse manager are approachable and addresses any concerns they may have.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>To ensure day to day operation is managed efficiently the clinical nurse manager steps up into the facility management role with support from the general manager and staff from other facilities owned and operated by the same organisation. Succession planning occurs to ensure the provision of timely, appropriate and safe service delivery is maintained.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management system is understood and implemented by the staff. This includes the development and updating of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and restraint and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. All corrective actions are reviewed and evaluated. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Information collected informs ongoing planning processes to ensure residents' needs are met. The quality improvement plan describes objectives, goals and actions either taken or to be taken to achieve positive outcomes.</p> <p>Policies and procedures are developed and reviewed at organisational level. The review process ensures that updates occur at least two yearly or sooner if there are changes to good practice or legislation. The policies sighted reflect good practice and link specialist resources and information, such as current pressure injury prevention and management. All staff have access to the current policies and they are kept informed on any changes through staff meetings and the staff notice board. There is an archive system in place for obsolete</p>

		<p>documents.</p> <p>The key components of service delivery are standing agenda items for management and staff meetings. The monthly quality data collected is trended and reviewed by the senior management team and corrective actions are put in place if any deficits are noted. One example relates to a newly developed form being used for residents who may be at risk of absconding. Staff are happy with the form and understand the reason for use.</p> <p>Quality information is used to inform business and strategic planning processes. Staff, resident and family/whānau interviews confirmed any concerns raised have been addressed by management and they gave verbal examples of quality improvements made.</p> <p>The business continuity and risk management plan sighted was updated in March 2016. Actual and potential organisational risks and hazards are documented. This includes a hazard and risk register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>A policy for reporting incidents/adverse events was sighted and management understood when statutory authorities should be involved, such as police for missing residents. Incidents are discussed at staff and management meetings.</p> <p>An incident register is maintained for all incidents/adverse events and several incident report forms were reviewed. There was evidence of follow up, close-off and notification to family members, as required.</p> <p>Staff were aware of the procedure for reporting incidents, were encouraged to be involved in the reporting process and were comfortable doing so.</p> <p>A list of monthly incidents/adverse events is recorded on meeting minutes and analysed to make improvements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the</p>	FA	<p>A recruitment process is defined in policy and includes credential checking, police vetting and reference checking, all of which were evident in the staff files reviewed. Qualifications reviewed were appropriate and current. Annual practicing certificates were identified for all health professionals and were current.</p> <p>Each staff member has a position description and employment contract. Orientation is provided that is appropriate for the position. The staff orientation programme includes</p>

<p>requirements of legislation.</p>		<p>incidents/adverse events reporting, health and safety and essential components of service delivery. The staff who work in the dementia unit have a specific orientation to management of behaviours of concern. Staff appraisals are carried out annually and recorded in the staff files reviewed.</p> <p>An annual training schedule covers compulsory and position appropriate in-service training and is delivered on a monthly basis. This includes pressure injury management. The RN has a current interRAI competency. All staff who work in the dementia unit have completed or are in the process of completing the required national qualifications in dementia care. The diversional therapist and activities coordinator have completed specific training in dementia care. An individual training and attendance record is maintained for each staff member.</p> <p>Staff are encouraged to request additional training requirements and there is evidence of this being provided. Staff reported that the training and orientation provided meets their requirements. Feedback from staff on training delivery is recorded in the training schedule. The residents, family/whanau and GP all report satisfaction with the skill and knowledge of the staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels and skill mix policy ensures resident needs are safely met. The facility manager is aware of the need for staff to complete specific dementia educational papers to work in the secure dementia unit. Seven staff have completed all dementia care qualifications and 11 staff are part way through completion of this.</p> <p>Rosters sighted (six weeks) identify that staff are replaced for sick leave and annual leave by a suitably qualified and skilled replacement.</p> <p>There is a registered nurse on all shifts. The facility manager and clinical nurse manager work five days a week. The secure dementia unit is operated as two areas. One is for men only and one is mixed. The men only area has two staff on every shift and the mixed unit always has at least one dedicated staff member. Staff and management are aware that dedicated staff cannot be used in other areas of the facility. The hospital and rest home area staffing meets contractual requirements. There are dedicated activities staff six days a week and kitchen staff seven days a week. Laundry and cleaning is undertaken as part of the health care assistants' daily tasks. All staff report they have enough time to complete all expected tasks.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	<p>FA</p>	<p>Information is entered into the residents file on admission by the clinical nurse manager or most senior RN on duty. A register is kept of current and past records. Archived records are</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>stored securely on site; these are retrievable as required. All records pertaining to individual residents are integrated. The progress notes record the staff members name and designation.</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. The residents' files are securely stored in a locked trolley in the nurses' area.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The facility manager and owner are responsible for resident entry to the service. The enquiry form records all enquires and if the potential resident has an appropriate assessment for secure dementia care, rest home or hospital level of care. There is a pre-entry assessment. The service may offer 'day stay' or respite for these residents before accepting the resident.</p> <p>All residents' files reviewed contained an appropriate needs assessment for rest home-secure dementia, rest home and hospital level of care. The facility manager reported a good working relationship with the DHB mental health services and that all referrals from the DHB have appropriate needs assessments. The service updates any vacancy on the Eldernet website each weekday.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>When admission has been required to the acute care hospital, the service utilised the DHB's transfer form/envelope. The referral process documents any risks associated with each resident's transition, exit, discharge, or transfer. This includes expressed concerns of the resident and family/whānau and a copy of any advance directives. Along with the transfer form/envelope, the RN reported that the service also provides a copy of any other relevant information.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medication procedures are implemented to meet legislative and best practice requirements, which includes processes for controlled drug management and residents who are assessed as able to self-administer their medications.</p> <p>Medications are stored in locked storage areas in the rest home/hospital section of the service. Medications that require refrigeration are stored in the medication fridge, with the temperature maintained at the recommended guidelines.</p> <p>The medications are individually prescribed for each resident. There is no bulk supply of medications. Medications are delivered by the pharmacy in a pre-packed administration system. These medication sachets are checked for accuracy by the RN. The medication charts</p>

		<p>and prescriptions have the required information and are either hand written by the GP or a pharmacy generated medication chart that is signed by the GP.</p> <p>All staff who administer medications or assist with the checking of the controlled drugs are assessed as competent to do so.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a four-week rotational menu that has summer and winter variations. This menu has been reviewed in the last year. Residents with specific nutritional needs have these met. The kitchen staff receive a copy of the nutritional requirements for each resident. Residents are routinely weighed monthly. Nutritional supplements are available to residents assessed as requiring these. The clinical nurse manager reports there have been no issues with unintentional weight loss. Food and nutritional snacks are available 24 hours a day.</p> <p>The kitchen services are based on the Hazard Analysis Critical Control Points (HACCP) principles for food safety. There are appropriate processes in place for the purchasing, preparation, storage and disposal of food that complies with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The facility manager and owner reported they have not declined entry to a potential resident (who has had an appropriate assessment) when there has been a bed available. If the service is to decline entry to a potential resident, this would be recorded on the enquiry form. The facility manager and owner reported that the referrer and family would be informed if a referral is declined with this being recorded on the pre-entry assessment form.</p> <p>The admission agreement contains the requirements of the contract with the DHB. The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident. As the service provides rest home, hospital and secure dementia care to residents assessed as requiring psychogeriatric care, should the needs of the resident increase beyond this level, the resident is reassessed and referred to the appropriate service. The service has had occasions where residents have been required to transfer to a service providing psychogeriatric care shortly after admission.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and</p>	FA	<p>The assessments and reassessments are conducted using the electronic interRAI assessment process. All files have an interRAI assessment. The service also uses their own paper based assessments for additional needs that are identified through the assessment process, this includes behaviour assessments. There is a summary of the assessed needs of the resident</p>

recorded in a timely manner.		and these are then documented on the care plan.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plans are based on the outcomes from the assessments and the identified needs of the resident. The care plans and resident needs are reviewed and documented as part of the fortnightly RN meetings.</p> <p>Each resident in the dementia units has plan of how to manage any behaviours of concern through the day and night. The care plans have specific information on the resident's mental abilities, awareness and confusion. There are specific entries for the behaviour management. The challenging behaviour assessments, monitoring forms and care plans reviewed described the triggers and de-escalation techniques for the prevention and management of the identified behaviours.</p> <p>The care plans evidenced family consultation and input into their planning.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The provision of services and interventions are consistent with meeting the needs of the residents. The resident's records were individualised and personalised. The care plan format includes the resident's specific needs, goals/aims and staff interventions required to address those needs. The care provided is flexible and focused on promoting quality of life in a safe environment. All relatives/whanau interviewed reported satisfaction with the care and service delivery. The relatives/whanau of residents living in the dementia units also had compliments on how the service has managed and limited their relative's episodes of challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The residents are included in meaningful activities. There is an activities coordinator Monday to Friday and staff assist with the planned and diversional activities over the weekend. The staff reported that they gauge the response of residents during activities and modify the programme according to the capability and cognitive abilities and age mix of the residents. There are specific groups for the younger residents. Residents have the option to participate in household duties, cooking, cleaning, maintenance, yard work and caring for the animals if they wish. Residents have the option to assist in other activities such as posting items and assisting with purchasing kitchen supplies.</p> <p>The activities programme covers physical, social, recreational and emotional needs of the residents. There are diversional plans on activities that can be conducted over a 24-hour</p>

		<p>period. Each resident has a diversional therapy, activities, social and cultural assessment. The residents were observed to be participating in meaningful activities both inside and out in the grounds of the service. The environment provides secure spaces for the residents to wander freely. The residents and family/whanau reported satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are conducted at least six monthly using their own paper based evaluation record. The care evaluations are conducted for all the resident's needs. The built in evaluation scores when the service reassess the resident using the interRAI assessment are also used to update the care plan after the evaluation has occurred. The evaluation records how the resident's goals have been met over the past six months.</p> <p>When there are changes in the resident's needs, the service uses a short term care plan to capture these changes. The short term care plans identify the need, interventions and evaluation of the interventions. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service has one main GP, though residents were able to maintain their own GP if available. There is evidence that the GP arranges for any referral to specialist medical services when it is necessary. The resident's files had appropriate referrals to other health and diagnostic services. All resident files sampled in the dementia unit confirmed input from mental health services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The organisation has policy and procedures in place to guide staff actions in ensuring visitors, residents and staff are protected from harm as a result of exposure to waste or hazardous substances. General waste disposal and recycling items are removed by the local council. There are approved sharps disposal bins which are removed by an approved contractor as required.</p> <p>Personal protective clothing and equipment (PPE) such as goggles, disposable gloves and aprons are readily available to all staff. Staff were observed using PPE at appropriate times. Staff confirmed their knowledge of the correct use of PPE during interview.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness is displayed at the entrance of the facility. Monthly warrant of fitness checks are sighted. Electrical equipment is checked by an approved provider. Annual calibration of the medical equipment is current. The facility holds compliance records for contractors.</p> <p>The physical environment minimises risk of harm with an uncluttered corridor with secured hand rails. The floor surfaces are intact.</p> <p>Both areas in the secure dementia unit have easily accessed outdoor areas with raised gardens containing all edible plants and shaded areas. There is also well set out gardens with shaded areas for rest home and hospital residents.</p> <p>The residents and family/whanau reported a high level of satisfaction with the environment at Capella House.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Residents are provided with adequate toilet and shower facilities which assure privacy. There are separate designated staff and visitor toilet facilities. There is a monthly recording of the hot water temperatures, the readings were within the required range. Residents /family/whanau did not report any concerns related to toilet or shower facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All bedrooms are single occupancy and personalised to reflect resident likes. The bedrooms are of a size that allow residents to move around safely with or without the use of mobility aids. All the beds in the facility are electronic hospital beds. Residents/family/whanau report satisfaction with the bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>All areas have lounge, dining and activity areas for residents. The men only secure dementia unit has a combined lounge dining area which residents/family/whanau report as being suitable to meet their needs. Activities are undertaken both indoors and outdoors. The mixed secure dementia unit has a lounge/dining area separated by furnishings and flooring. The rest home/hospital facility has a large television lounge and a quiet lounge. Both areas are used for activities. There are separate dining areas.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Environmental audits and laundry services audits record the effectiveness of the laundry and cleaning processes, including waste management procedures. Staff confirm if any deficits occur they are informed and a corrective action is put in place. Chemicals are securely stored in a locked cupboard and the laundry. Safety data sheets are available for all products used at the facility.</p> <p>The staff demonstrated knowledge of the cleaning and laundry process, which reflects safe infection control procedures. The residents and family/whanau report satisfaction with the cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has civil defence supplies for emergency use. This includes storage of drinking water and food. There is emergency lighting and back up gas supply for cooking should it be required. The emergency equipment is inspected monthly by both internal auditing and by the contracted inspection company's independent qualified person. There is a fire service approved evacuation scheme. Six monthly evacuation drills conducted. The review of staff records identify emergency training is included in the orientation/induction programme and annually thereafter. Staff verbalised their knowledge of the actions to take in an emergency situation.</p> <p>Call bells are located in all resident areas and when activated there is an audible alert and a light on a control panel to identify which room has activated the call bell.</p> <p>Night time security processes are conducted by the staff, and includes the locking of external doors and windows. The evening staff do rounds to ensure the doors and windows are locked. There are cameras in the shared areas such as hallways and focused on the entrance door. This is monitored in the facility manager's office. Residents and staff stated they feel safe at all times in the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All resident areas have at least one opening window to provide natural light and ventilation. Heating is electric and the central heating unit allows the facility to remain at an even, controlled temperature. This is confirmed by residents and family/whanau during interview.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control coordinators (clinical nurse manager and another RN) have job descriptions that outline their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meeting, at which the senior management (the clinical nurse manager) is present. Each resident with an infection has an infection incident report and short term care plan for the infection. The infection control programme has been reviewed in the past 12 months. The review included review of infections, policies and procedures, quality controls, staff training and resident education.</p> <p>There are processes in place to ensure staff and visitors suffering from infections do not infect other. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>Infection control matters are discussed at the monthly staff meetings. If the infection control coordinators require additional advice or support regarding infection prevention and control they can access this through the nurse specialist, DHB, GP or diagnostic services.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection policies and procedure have been developed by an aged care consultant and are current. They cover all aspects of infection control management, including the correct use of personal protective clothing/equipment. These policies are appropriate to the services offered by the facility.</p> <p>All staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinators conduct most of the infection control education. There are some visiting specialists who provide infection control education. The infection control coordinator interviewed demonstrated knowledge on current good practice in infection prevention and control. Both the infection control coordinators have attended ongoing education on infection prevention and control to keep their knowledge current.</p>

		As the majority of residents have some degree of cognitive impairment, resident education is not always appropriate. There is reinforcement of infection control practices and health promotion at the resident meetings.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is monthly collection, collation and analysis of infections. The service uses standardised definitions, applicable to aged care, to identify infections. The type of surveillance undertaken is appropriate to the dementia care service. Data is collected on urinary tract infections, influenza, skin infections, respiratory tract infections, communicable diseases and gastro-enteric infections. Monthly infection surveillance records sampled confirm analysis of the numbers and types of infections, with the actions implemented to reduce infections.</p> <p>The infection data reviewed confirm that in the event of an increase in infections, actions are implemented to reduce reoccurrence. Where there has been an increase in a month, the infections have been reduced in subsequent months.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are procedures in place to guide staff should restraint be required. Policy identifies that the use of enablers is voluntary and should be the least restrictive option to meet the needs of the resident to promote independence and safety. Staff were aware of the difference between an enabler and a restraint and what actions need to be taken related to the use of both. At the time of audit, the service had no restraints and four residents with enabler use of a bed loop to assist with getting in and out of bed. The enablers are voluntary and used to enable the resident to feel safe and increase their mobility.</p> <p>There is no restraint in the dementia units, with the environment designed for residents with cognitive impairment to wander freely and safely. There is a security code gate on the drive way, with the code displayed, so the rest home and hospital residents and all family/whanau can freely come and go through the front gate (as confirmed in policy and consent forms sighted). The gate is linked to the emergency alarm system and automatically unlocks when the fire alarm is activated.</p> <p>Staff undertake annual education related to restraint minimisation and were able to verbalise de-escalation methods used to prevent any restraint use. Staff have attended training on restraint minimisation, de-escalation and the minimising of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>Records of complaints were sampled, as per the complaints register. This identified the current status of the complaint (open or resolved). In the event the complaint had been resolved, the corresponding actions were not consistently documented.</p>	<p>Follow up actions taken to resolve complaints are not consistently documented.</p>	<p>Provide evidence that all follow up action taken to address a complaint is clearly documented.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the</p>	PA Low	<p>Long term care plans are developed within three weeks of admission. The initial nursing assessment and initial care plan is documented on the day of admission. The assessments and care planning identify the physical, spiritual, psychosocial and cultural needs of the residents. The care plans are evaluated at least six monthly or sooner if there is a change in need.</p> <p>Assessments are conducted on both the organisational assessment tools and interRAI. The initial interRAI assessments had not been</p>	<p>Time frames for service delivery have not been consistently maintained as required.</p>	<p>Provide evidence that the initial and ongoing interRAI assessments/reviews are completed within contractual timeframes.</p>

needs of the consumer.		<p>conducted within the contractually required 21 days from admission in five of the files reviewed.</p> <p>One of the files of a resident with an admission over six months has a care plan evaluation, though the interRAI assessment was conducted after the evaluation of the care plan and later than six months after the last interRAI assessment (seven months). The recommended nursing process and contractual expectations is to conduct the re-assessment using the interRAI as part of the six monthly evaluation process (or sooner if there is a significant change in condition).</p>		180 days
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.