

The Grail Movement Foundation of New Zealand Limited - Komatua Care Centre

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: The Grail Movement Foundation of New Zealand Incorporated

Premises audited: Komatua Care Centre

Services audited: Dementia care

Dates of audit: Start date: 20 October 2016 End date: 20 October 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: 11



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

Komatua Care is an 11 bed aged care service that provides specialist secure dementia level care. At the time of audit there were 11 residents.

This unannounced surveillance audit was conducted against the relevant Health and Disability Service Standards and the organisations contract with the district health board. The audit process included the review of resident and staff files, observations and interviews with family, management, staff and the general practitioner.

The five previous areas for improvement were also reviewed. These have all now been sufficiently addressed. There were no new issues or shortfalls identified.

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.		Standards applicable to this service fully attained.
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Residents and family receive full and frank information and open disclosure from staff. There are effective methods of communication for residents with cognitive impairment. There are processes in place to access interpreting services should this be required.

A complaints management system is implemented. The complaints register contains all required and relevant information and actions taken to address any concerns. There have been no recorded complaints in 2016.

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/manager is suitably qualified and experienced. The manager is supported by the trustees, the registered nurse and staff. The organisations mission, vision and philosophy are clearly identified and recorded. Annual business plans and quality plans are developed and reviewed.

The required policies and procedures are documented and implemented. Quality related data is captured and used to improve services. Organisational risks are identified and monitored. The adverse event reporting system is planned and coordinated.

Systems for human resources management, processes for employment, orientation and ongoing education are in place. All staff have the required training and competencies. Staff performance is monitored.

There are sufficient staff numbers on each shift with extra staff available as required.

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.
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Residents' needs are assessed on admission within the required timeframes by a registered nurse. Care staff are on duty 24 hours each day in the facility and are supported by allied health staff, the registered nurse, the resident manager and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. Families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed as per policies and procedures, current good practice and legislation. Medication administration is consistently implemented using an electronic system. Medications are administered by care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen is organised, clean and meets food safety standards. Residents verified satisfaction with meals.

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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All building and plant equipment complies with legislation and a current building warrant of fitness is displayed. Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of a fire.

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 organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and one restraint was in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control surveillance programme is appropriate to the size and scope of the service.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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	18	0	0	0	0	0
Criteria	0	47	0	0	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints process meets the requirements of Right 10 of the Code. The process for making a complaint is explained as part of the admission process for residents and family. Staff are orientated to the complaints process on commencement of employment.</p> <p>Family members interviewed confirmed that the owner/manager has an open-door policy and is approachable. Records of complaints, and a complaints register are maintained. There were no outstanding complaints at the time of audit and there have been no internal or external complaints since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There are documented procedures which support open disclosure. Family members interviewed confirmed that they are informed if the resident has an incident, accident or a change in health status. Family contact is recorded in residents' files when required. It is reported that interpreter services are available from the district health board (DHB); however there have been no residents requiring interpreting services.</p> <p>Family, guardian or an enduring power of attorney sign the admission agreement on entry to the service. The agreement provides clear information regarding what is paid for by the service and by the resident. The required admission agreements were sighted in files sampled.</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>	FA	<p>The organisation has three trustees, one of which is the owner/manager and one whom also works on site as a health care assistant. The owner/manager is responsible for day to day operations. In the event of absence of the owner/manager, the other trustee is given the delegated authority to fulfil the role.</p> <p>The mission, values and goals are documented in the business plan. There is evidence that the business plan is reviewed and updated annually. The owner/ manager has been in the role for over 30 years and regularly attends education relevant to dementia care. Education records were sampled.</p> <p>The rest home provides care to residents who have been assessed as requiring dementia level care. The majority of residents are over 65, with two under 65. There were 11 residents on the day of the audit – eight with ARRC contracts and three with LTC contracts.</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>There is a documented and implemented quality and risk management system. The owner/manager is responsible for ensuring that all quality and risk management activities are implemented with clinical oversight from the registered nurse.</p> <p>The required policies and procedures are documented. These are developed by an external consultant. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff and staff orientation includes an introduction to the system. All documents sampled were current and controlled.</p> <p>Quality goals are developed annually. Achievement towards quality goals is documented. Quality activities and quality data are discussed and monitored through monthly staff meetings. This includes complaints, review of incidents and accidents, health and safety and the results of internal audits. Audit action forms are maintained which include all the corrective actions from the previous month. There is an annual review of all aspects of the quality and risk management programme including infection control.</p> <p>Family are kept informed through regular newsletters. There is an annual family satisfaction survey with family indicating that they are satisfied or very satisfied with all aspects of care. This was confirmed in interviews with all family members.</p> <p>The organisation has a risk management programme in place. Organisational risks are documented in the business plan. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of the hazard register being updated as new hazards are identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	FA	<p>There is evidence that adverse events are reported as required. In interview, the owner/manager understood their obligations in relation to essential notification reporting, for example Section 31 notification in the event of</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>		<p>a pressure injury. Incident and accident management is included in staff orientation.</p> <p>A number of incidents were sampled. These provided sufficient evidence that adverse events are linked to the quality system and used as opportunities to improve services. The majority of incidents are related to behaviours of concern or falls. There is evidence that families are notified of any adverse. This was also confirmed in interviews with family members.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The registered nurse (RN) has a current annual practicing certificate (APC). Current practising certificates were also sighted for other health professionals who work with the organisation, for example the general practitioner (GP) and pharmacists. All health care assistants have achieved, or are working towards, the required dementia training. All staff have a current first aid certificate and a food safety certificate was sighted for the cook.</p> <p>All staff receive an orientation on commencement of employment. Orientation checklists were sighted in all staff records sampled. The orientation includes the essential components of service delivery.</p> <p>On-going education is provided. The education programme includes aspects of aged care and dementia. Seven of the eight staff have completed InterRAI training, with one staff member being the consistent user. The required competencies are maintained and monitored, for example medication competencies. In addition, articles of interest are presented at staff meetings, and signed off as read by staff. This has recently included the prevention and treatment of pressure ulcers and the RN has recently attended palliative and complex wounds training which was presented by the DHB gerontology nurse practitioner.</p> <p>Staff performance is monitored. The required annual appraisals and skills assessments were sighted in staff files sampled.</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>There is a documented policy on staffing levels and skill mix. There is one to two staff members on the roster for each shift. In addition the owner/manager and one staff member live on site and provide support as required, and are on call after hours. The registered nurse is on site three days per week and the cook is onsite Monday to Friday. The owner/manager reports that additional staff are called in when required, for example during busy periods, sick leave or annual leave. This was confirmed in both family and staff interviews.</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>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and legislation.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of the roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked against the prescriptions. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. There are no controlled drugs required in the facility at present, however controlled drugs if required, are stored securely in accordance with requirements. The records of temperatures for the medicine fridge were within the recommended range.</p> <p>The required three monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit.</p> <p>Medication errors are reported to RN and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in April 2015. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by observation, resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as: behaviour; wound; pain scale; falls risk; skin integrity; nutritional screening and depression scale to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. The previous improvement regarding outcomes and risk ratings has been addressed.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care over a 24 hour period. The attention to meeting a range of resident's individualised needs, including management of a diverse range of challenging behaviours was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care provided is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources is available, suited to the level of care provided and in accordance with the residents' needs.</p> <p>The previous improvement regarding supervision of residents when in the community has been addressed. All residents are escorted by the diversional therapist.</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 activities programme is provided by a trained diversional therapist, and caters to the specific abilities and needs of residents residing in a secure unit including the needs of the two residents under 65, over a 24hour period. The previous improvement regarding activities has been addressed.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as resident's needs change and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The activities programme offered is in addition to enabling the residents' participation in the day to day chores within the home. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include outings to the shops, community visits, coffee at the local café and local walks. The activities programme is discussed with family members and residents on an ongoing basis and input is sought and responded to. Resident and family interviews and satisfaction surveys demonstrated satisfaction with the programme and</p>

		that information is used to improve the range of activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections and progress evaluated as clinically indicated (daily, weekly or fortnightly) and per the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Families/whānau interviewed and documentation provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expires 29/10/17) is publicly displayed. There have been no alterations to the building since the last certification report. The environment provides safe areas that encourage purposeful walking, including access to safe outdoor areas. External areas are safely maintained and are appropriate to the resident groups and setting, with a new higher gate installed in February 2016 to minimise the risk of residents climbing over. This addresses the previous area requiring improvement. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The current fire evacuation plan has been approved by the New Zealand Fire Service, and there have been no changes to the building since approval has been given. A trial evacuation (due this month) takes place six-monthly, and was last held April-2016. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The service has had to disengage the call bell system and has replaced this with two GPS watches that are linked to individual staff cell phones. The system is only required when the residents are not within the home, and in the presence of others. Staff wear a GPS watch and the resident wears a tracking device, when they leave the facility. The staff can then request assistance from other staff, by activating the watch which is connected to the facility's phone. Residents, while always supervised when leaving the facility, can be tracked if they happen to wander off by themselves.

		<p>There is an emergency button that can be called at any time. The call will ring on the phone in the service and on the cell phones connected to the system. The owner/manager confirmed that they can respond to the call on the phone when they are on call.</p> <p>The previous improvement regarding the call system has been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>A surveillance programme is maintained. Surveillance data was sighted and included infection details related to files sampled. Infection control surveillance monthly analysis is completed and reported at monthly staff meetings. The infection control surveillance is appropriate to the size of the service.</p> <p>Information gathered is clearly documented in the infection log maintained by the infection control coordinator. Surveillance for infection was carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented. Infections were investigated and appropriate plans of action were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. Staff demonstrated a sound understanding of the organisation's policies, procedures, and practices and their responsibilities in relation to restraint and enablers.</p> <p>On the day of audit, one resident was requiring the use of a restraint and no residents were requiring the use of enablers.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.