# Graceful Home Shoal Bay Limited - Shoal Bay Dementia

## Introduction

This report records the results of a Provisional 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 HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Graceful Home Shoal Bay Limited

**Premises audited:** Shoal Bay Dementia

**Services audited:** Dementia care

**Dates of audit:** Start date: 24 August 2017 End date: 25 August 2017

**Proposed changes to current services (if any):**  Graceful Home No.2 Limited intends to take ownership of the rest home on 20 November 2017 depending on the outcomes of the provisional audit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 24

# 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.

## General overview of the audit

Shoal Bay Villa Rest Home can provide care for up to 26 residents. This provisional audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. A change in ownership is anticipated to occur on the 20 November 2017 after approval by HealthCERT through this audit.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with family, management, staff and a medical officer. The potential owner was interviewed.

The potential owner has completed the requirements for owning a new rest home - dementia and was well prepared. The potential owner already owns another rest home, dementia unit and home care service. There are no intentions to change existing service delivery or the environment should the sale of the service be confirmed.

Improvements are required to the following: advance directives; documentation by the registered nurse in progress notes; analysis of the family satisfaction survey; human resource processes; integration of resident records; review of specialised assessments; the activities programme; water in the event of an emergency.

## Consumer rights

Residents receive services in line with the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). The systems protect their privacy and promote their independence. There is a documented Maori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents’ values and beliefs.

Management and staff communicate in an open manner and residents and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

The rights of residents or their legal representatives to make a consumer complaint is understood, respected and upheld. An up-to-date complaints register is maintained. Consents are documented by residents.

The potential owners are familiar with the Code and describe implementation of this for residents.

## Organisational management

There is an annual business plan in place which defines the scope, direction and objectives of the service and the monitoring and reporting processes. The service is managed by the owner/manager who is a registered nurse with a current practising certificate.

There is an established quality and risk management system in place. There are a range of policies and associated procedures and forms in use to guide practice. Data is collected and mostly analysed to improve service delivery. An internal audit schedule is in place. Adverse events when documented, are reported to management and external agencies. The potential owners use similar policies developed by an external consultant and will gradually change the policies in this service to their ones.

Staff in the dementia unit have completed dementia training and new staff who have not yet started are always rostered on with senior staff. Staff are knowledgeable and skilled. There is a clearly documented rationale for determining staff levels and staff mix in order to provide safe service delivery. An appropriate number of skilled and experienced staff are allocated to each shift.

Resident information is stored securely.

## Continuum of service delivery

The owner/manager (registered nurse) is responsible for the development of care plans with input from the residents, staff and family/whanau representatives. Care plans are developed and evaluated within the required time frames that safely meet the needs of the resident.

Planned activities outlined in the activities programme are appropriate to the residents assessed needs and abilities.

A medicines management system is in place and medicines are administered by staff with current medication competencies. All medicine charts are reviewed by the general practitioner (GP) every three months or whenever necessary according to policy.

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

## Safe and appropriate environment

All building and plant complies with legislation with a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The dementia service is secure. Outdoor areas are available for residents.

Essential emergency and security systems are in place with regular emergency drills and staff training completed.

## Restraint minimisation and safe practice

There is a designated restraint coordinator. Restraint is not used in the service and there are no enablers in use. Staff receive ongoing sufficient education to manage challenging behaviours. Policies and procedures on restraint and enabler use are current.

## Infection prevention and control

The infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 36 | 0 | 3 | 6 | 0 | 0 |
| **Criteria** | 0 | 82 | 0 | 3 | 7 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place to ensure resident rights are respected by staff. Staff receive education during orientation and ongoing training on resident rights is included in the staff annual training schedule. Staff interviewed are all able to articulate knowledge of the Health and Disability Commissioner’s Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. Staff interviewed confirm they receive ongoing education on the Code. Visual observations during the audit and the review of clinical records and other documentation indicate that staff are respectful of residents and incorporate the principles of the Code into their practice. The service provides information on the Code to families and residents on admission. Residents and family interviewed state that they receive services as per the Code.The potential owner was interviewed and confirm knowledge of the Code and advocacy services. Examples were given of application of the Code into their current businesses.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff mostly use verbal consents as part of daily service provision. Staff demonstrate an understanding of informed consent processes. Residents and relatives confirm that consent issues are discussed with the relatives and residents on admission. All residents' files reviewed include documented written consent. There is a policy that reflects evidence and best practice around advanced directives. There is a requirement to ensure that practice reflects the policy. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Information on advocacy services is available in the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff. Discussions with family identifies that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident’s family and chosen social networks. The potential owner confirmed their understanding of advance directives in the context of a dementia unit.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | There are no set visiting hours and family report that they are encouraged to visit at any time. Family confirm that residents are supported and encouraged to access community services or as part of the planned activities programme and through family outings. The service encourages the community to be a part of the residents’ lives in the service with visits from entertainers. The potential owner interviewed described encouraging family to be a part of the service. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints. Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Family confirm that the management open door policy makes it easy to discuss concerns at any time.Training around the complaints policy and process is part of the staff orientation programme and ongoing education. The complaints register records the complaint, dates and actions taken. Three complaints reviewed indicate that timeframes are met as per the policy. There are no outstanding complaints at the time of the audit and the owner/manager confirms that there have been no complaints to external authorities since the last audit.The potential owner interviewed confirmed knowledge of the complaints process.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Information on the Code and the Nationwide Health and Disability Advocacy Service are displayed in the facility including pamphlets available for residents and family in the owner/manager office, as there is a resident who is currently tearing information up. Family confirmed that they knew where to find information. Information around advocacy services and the Code is included in the admission information pack and described by the owner/manager as being discussed with residents and relatives on admission.Residents and relatives interviewed confirm that the Code, the advocacy service, and residents’ rights are explained on admission. They also state that they can discuss any concerns with the owner/manager and other staff particularly the senior staff at any time. The potential owner confirmed that they will keep an open door approach that allows residents or family to talk to them at any time.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are a range of policies and procedures in place to ensure residents are treated with respect.Staff endeavour to maximise residents’ independence by encouraging residents to actively engage in cares and to continue to access the community as long as possible. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit. Residents and relatives interviewed state that staff have regard for the dignity, privacy, and independence of residents. There are quiet, low stimulus areas that provide privacy for residents in the dementia unit. The potential owner described how they treated residents and family with respect and dignity in other rest homes that they own with examples given. There is no evidence of abuse or neglect. Policies and procedures are explained by staff with a description of how they would escalate any issues of abuse or neglect if these were identified. Procedures described are in line with the policy. Staff, family members and the general practitioner interviewed confirmed that there was no evidence of abuse or neglect. A review of incidents for the last year did not indicate that any abuse or neglect had occurred.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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. | FA | There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care provision for Maori residents. The documentation is referenced to the Treaty of Waitangi.Staff interviewed confirm an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training. On the days of audit there were resident/s who identified as Māori and staff interviewed described how they had asked family, about the care they should and could provide for the resident. In each resident file, there is evidence that a cultural assessment is completed with documentation of interventions in the long-term care plan.Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes including input from family/whanau as appropriate, for residents who identify as Māori. The potential owner identifies as Māori and speaks te reo. They have extensive links with Māori if required.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirm their understanding of cultural safety in relation to care. Family members interviewed confirm that values and beliefs are respected by staff. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. Staff demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the health care assistant role and responsibilities.The owner/manager and staff are very aware of the need to ensure that the residents in the facility are supported and not taken advantage of in any way. Examples were able to be given with strategies to address if this occurred.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice. These align with the health and disability services standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external consultant. Evidence based guidelines, treatment protocols, reference material and resources are available and utilised by staff. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice.The education programme is documented (refer 1.2.7) and staff can access health professionals from the District Health Board as required. Family members interviewed confirm they are very happy and satisfied with the care provided to their relatives living in the dementia unit.The potential owner interviewed described good practice with examples given of oversight of each facility they currently own. This includes monitoring of indicators and completion of key tasks; a hands-on approach to management and a management team who can provide support to other facilities if required.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service provider has policies covering communication, access to interpreters and maintains an open-door policy. Information is provided in a manner that the resident can understand. Relatives can discuss issues at any time with staff. The incident and accident forms include an area to document if the relatives have been contacted and a record of communication with family members is retained in each resident file. Open disclosure is practised and documented when family are contacted.Relatives interviewed confirm that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirm that they are advised if there is a change in their family member's health status. The general practitioner interviewed reported satisfaction with communication from staff.There is a policy around use of interpreters and access to interpreting services is documented. Residents in the service all speak English as their first language however staff are able to describe using family and other interpreting services to interpret for the resident if that was required in the future. Because residents in the unit often do not communicate well verbally, staff describe looking at body language and using other ways of identifying resident needs. This includes asking family about the resident and to tell them if there are cues they are missing. Staff also describe using simple language and giving simple choices for residents who have dementia or who find communication difficult. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service is for sale and the potential owner has commissioned a provisional audit. Shoal Bay Villa Rest Home is potentially to be purchased by Graceful Home No.2 Limited. The prospective owner has an established organisational structure, with the sole director being supported by a business partner (accountant) who provides financial support. The director also owns a home care service; a rest home since February 2014 and a dementia unit in close proximity. The potential owner has visited the service and is confirmed by the current owner as able to be transitioned into the service. They have had previous experience in working with people with disabilities and challenging behaviour. There planned settlement date is 20 November 2017. The prospective owner’s intention is to retain the current service as is. Any changes are expected to be gradually introduced once the potential owner identifies any issues. The potential owner has staff in other services who are trained in supporting residents in dementia units and they include managers and registered nurses who will be able to support any staffing needs in the early stages. The organisation is currently privately owned with the owner/manager also the registered nurse who provides oversight for the service. The owner/manager is on site during weekdays and also during the weekend at times.The business has agreements in place with Waitemata District Health Board for the provision of aged residential care at rest home – dementia level of care. Of the 26 beds identified as being certified, 24 are occupied on the days of audit. The purpose, values, priorities and goals are documented in the annual business and quality plan for 2017 to 2018. The goals are reviewed annually by the owner/manager. The owner/manager is responsible for ensuring services are planned, coordinated and appropriate to meet the needs of the residents. The owner/manager has a current annual practising certificate and has owned the business for over 10 years. The owner/manager is supported by the clinical coordinator (enrolled nurse). Both the owner/manager and the clinical coordinator have competed at least eight hours of education in the last year to maintain their practising certificates. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | PA Moderate | During the temporary absence of the facility manager, the clinical coordinator and one other enrolled nurse is available and experienced to cover the service. The owner/manager states that they have never been away and are always available to staff when required. In the event of being on leave, the owner/manager states that if the enrolled nurses require access to a registered nurse, then the general practitioners practice would be rung. This includes ringing the on-call doctor if required. The owner/manager states that they would also be available by email if require. A requirement is in place to confirm access to registered nurse cover for the service if the owner/manager was unable to perform the role when on leave. The potential owner has access to registered nurses who are experienced in their other services. They state that there would be support from the registered nurses and from the potential owner who has a hands-on role if required. The potential owner confirmed that they are actively looking for a registered nurse to be employed in the service if the sale is successful.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The quality and risk management programme identifies objectives for the service. Activities within the programme are closely linked with health and safety, adverse event reporting, the infection prevention and control programme, restraint minimisation, and the resident complaints process. Quality related data and outcomes are collated, analysed and shared with staff at regular staff meetings. Policies are reviewed two yearly as defined by policy. The service uses an external quality and risk management consultant to provide advice on policies, procedures and forms. Policies sighted reflect current good practice, legislation and compliance requirements with policies current (last reviewed in 2017). The potential owner uses an external consultant to develop policies. The policies are similar and the potential owner would introduce their policies slowly to allow staff to transition to the ‘new look’. All documents sampled are controlled and obsolete documents removed from circulation. Policies and procedures and the internal audit schedule include reference to interRAI and care planning processes. The internal audit schedule is documented annually. Internal audits are planned and corrective actions are documented and implemented where a variance is identified. Corrective actions are discussed at staff meetings and linked to the quality and risk management system. There is documentation of resolution of issues. There is a process implemented to measure achievement against the quality and risk management plan. Trends are reviewed to improve service delivery. The potential owners described a monitoring system already in place across the rest homes they currently own. They state that this ensures that trends are reviewed and improvements put in place as a result of this. The potential owner confirmed that they will monitor the service with trends analysed across both dementia units. The service has completed a satisfaction survey last in January 2017. The results are not collated and an improvement is required. A risk management plan is documented. The risk register is maintained with evidence that any risks identified are proactively recorded on the register. Health and safety requirements are being met, including hazard identification. Health and safety systems have been reviewed since the introduction of the Health and Safety at Work Act 2015. The current owner/manager and the potential owner are both familiar with the legislation. Training for staff around health and safety was last provided in 2017.The prospective provider intends to continue with the quality and risk management programme. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported although the owner/manager states that there have not been any incidents that have required reporting since the last audit. The incident forms that have been completed show evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner when incidents occur. Both family and the general practitioner interviewed confirm that incidents are reported in a timely manner. The review confirmed that documented incidents and accidents are closed following review by the owner/ manager and linked to the quality system. Monthly statistics on all documented adverse events are collated, analysed and reported at staff meetings.The owner/manager and potential owner understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The potential owner states that the same system for reporting and monitoring of incidents occurs in facilities they already operate.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Moderate | There is an established system in place for human resource management.All staff records reviewed include an employment agreement and a position description. Staff do not have criminal vetting prior to appointment. Professional qualifications are validated. All staff receive an orientation and participate in ongoing refresher education. Reference checks are not routinely completed. Performance appraisals are not always completed annually as per policy for all staff. The owner/manager is a registered nurse and is interRAI trained. The potential owner interviewed confirms that their current facilities have interRAI trained staff with an interRAI trained registered nurse able to provide support when required. Medicines are given by the owner/manager and healthcare assistants who have been assessed as competent. All staff have completed training in dementia apart from new staff who have recently been employed. Any new staff member is always rostered with a more senior staff member as confirmed by staff interviewed and through a review of rosters. A training plan is documented and implemented annually however there is a requirement to offer more training for staff. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The process for determining provider levels and skill mix is defined in policy and takes into account the layout of the facility and levels of care provided. Staff rosters are developed by the owner/manager in conjunction with the clinical coordinator (enrolled nurse). Rosters and staff interviewed and observation on the days of audit confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the Aged Residential Care Agreement. Casual staff are available to pick up extra shifts when staff rostered are on leave with a review of rosters confirming that staff are replaced if absent. There is a staff member on duty with a current first aid certificate on each shift. The owner/manager is on site Monday to Friday and on call for clinical emergencies/concerns. Staffing is allocated to each area. There are three health care assistants in the service on the morning and afternoon shifts and two overnight. This includes one staff on a short shift in the morning and afternoon who is responsible for supporting the other health care assistant at busy times. The placement of staff in relation to the configuration of the facility has been considered and at times, there is evidence of residents who have been shifted to a room in a more central location when they require more oversight. Staff state that they can call for assistance at any time with staff stating that there is a prompt response when call bells are activated.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Moderate | Paper-based clinical records are maintained for each resident however each resident has their information held in a number of files. All records are maintained confidentially. The resident records are stored in a locked cupboard in the nurse`s station or stored electronically with appropriate back-up systems in place. The detail is adequate and records information important for ongoing care and support being provided. A record of past and present residents is maintained electronically. InterRAI assessments are completed by the owner/manager and inform the development of the residents plan of care. Progress records are clearly documented by the health care assistants in the paper-based record (refer 1.3.3). The date, time, signature and designation of those entering into the records is legible. An improvement is required to integration of records.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to service policy includes all the required aspects on the management of enquiries and entry. The service has a welcome pack that contains all the information about entry to the service. This includes information around the dementia unit. Assessments and entry screening processes are documented and clearly communicated to the family of choice where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines the dementia service provided as part of the agreement to entry. Family interviewed confirm that they received sufficient information regarding the services to be provided. Each resident file reviewed included a needs assessment that confirmed the resident required rest home – dementia level of care.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the District Health Board is utilised when residents are required to be transferred to the public hospital or another service. The exit and discharge process address risks. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | A detailed medication policy documented is reflective of current safe practice guidelines. The service uses Medimap and staff state that this has reduced the number of incidents. The policy identifies that staff who administer medicines must be competent. Health care assistants who administer medications have completed medication competencies for the 2017 year. The enrolled nurse observed administering the lunchtime medication complies with regulation requirements. Medicines are kept in a locked trolley with some oral medication and creams stored in a locked cupboard. A fridge is used to store medication with temperatures checked regularly. There are no residents requiring the use of controlled drugs. The owner/manager and enrolled nurse interviewed were able to describe a process for management of controlled drugs that included these being checked weekly by two staff, one of whom is a registered nurse should they be used. A review of the controlled drug register used in the past for administration of controlled drugs confirms that weekly stock takes have occurred. As required medications are charted with documentation of indications for use and maximum dose per hour. No residents self-administer medication and this is not expected to take place given this is a dementia unit. Medication records reviewed evidence photo identification on each resident record sheet with this confirmed as being a true and correct likeness. Any allergies or sensitivities are documented on the medical notes and the resident’s medication record. All medications are prescribed individually and signed and dated by the GP. There is no evidence of any transcribing of instructions. The clinical coordinator checks the medication packs when received from the pharmacy with documentation of reconciliation maintained. All medications are current with expiry dates checked and any expired medication returned to the pharmacy when identified. The pharmacist completes an audit of the system and of medications every six months. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Meal services are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian with this reviewed two yearly. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes (refer 1.3.4) with a whiteboard in the kitchen identifying any allergies or preferences. The resident’s weight is monitored regularly. A review of resident files confirmed that resident weight is stable and staff confirmed that there are no residents losing weight.The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The service provides additional food over a 24- hour period for residents with dementia if they require snacks outside of meal times. The family interviewed indicated satisfaction with the food service.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The owner/manager reports that any resident who is declined entry is recorded on the appropriate form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The resident is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider. There have not been any residents declined entry to date as the owner/manager states that the needs assessment clearly denotes level of care. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The initial assessments are completed within the required timeframe on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The owner/manager utilises standardised risk assessment tools on admission with these expected to be reviewed six monthly. In interviews, relatives expressed satisfaction with the assessment process. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are resident focussed and provide continuity of service delivery (refer 1.2.9). The assessed information is used to generate long term care plans and short-term care plans for acute needs. Short-term care plans are used for wounds and other short-term cares. Plans are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The relatives interviewed confirm care delivery and support is consistent with their expectations and plan of care.Behavioural assessments are used to underpin documentation of the behavioural plans with these reflecting interventions relevant to the individual.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short-term care plans and long-term care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the general practitioner. Progress notes are completed on every shift by the health care assistants (refer 1.3.3). Adequate clinical supplies were sighted and the staff confirm they have access to enough supplies including continence products. Family members interviewed report satisfaction with the care and support their family member is receiving. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | PA Moderate | The planned activities are meaningful to the residents. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they modify activities based on the resident’s response and interests and also according to the capability and cognitive abilities of the residents. The residents were observed to be participating in meaningful activities on the audit days. Staff state that attendance is voluntary however they try to encourage residents to attend with this observed on the days of audit. Residents were observed to be going out with family/friends during the audit. Entertainers provide activities at the service. There are planned activities and community connections that are suitable for the residents.Residents have a 24-hour activity plan in place that links with the long-term care plan for management of challenging behaviours. An improvement is required to the 24-hour activity plans and to documentation of the availability of one-to-one activities. The relatives interviewed report overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident’s long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes (refer 1.3.4). Family and staff input is sought when evaluation of plans is completed as confirmed by family interviewed. The evaluation records how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. The owner/manager or general practitioner facilitates all referrals.  |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Policies and procedures specify requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances on an annual basis.Chemicals are stored securely and the required personal protective equipment/clothing (PPE) is available. Staff confirm they can access PPE at any time and were observed wearing disposal gloves and aprons when these were required.The health care assistants demonstrate knowledge of handling waste and chemicals and were observed to keep the cleaning trolleys in sight when in use. Cleaners were particularly vigilant around keeping chemicals safe and in sight when in use at all times. Waste is mostly of a domestic-type and is managed via a recycling programme or by local council contracted services.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current warrant of fitness. There is a fire evacuation scheme (issued 10 October 2013) from the New Zealand Fire Service.The dementia unit is shaped around a central courtyard with the building secure. Planned and reactive maintenance is implemented by contractors. The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of the current residents. The electrical equipment is checked and records maintained. Testing and calibration checks of medical measuring equipment occurs annually. There are outdoor areas available for all residents including verandas and outdoor garden areas. The potential owner interviewed confirmed that there is no intention to change any part of the environment. They did state that they would respond to any maintenance issues in a timely manner as these arose.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are sufficient toilets, hand basins and showering facilities available for residents. Some bedrooms have a toilet and hand basin. The rest home has communal toilets and showers. There are appropriate privacy protections in place when showers and toilets are in use with these observed to be used on the days of audit.  |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All residents have their own room except for two rooms which are able to be double rooms used to accommodate couples. Each resident has their own bedroom on the day of audit. There is ample room for mobility aides to be used safely in each resident’s room. Family confirm that there is sufficient space in each room for personal items. Bedrooms contained personal items.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large lounges in the dementia unit. The lounges are also used for activities. There are two main areas identified as dining rooms. Staff state that a number of activities occur outside in the courtyard and on this was observed on the second day of audit.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are separate laundry and linen service manuals available and reviewed containing all relevant cleaning and laundry policies and procedures to guide staff. Staff know how to access the information and can describe implementation as per policy.The service employs a cleaner seven days a week. All cleaning processes are documented. There is adequate storage for all chemicals in a locked designated area. The cleaner washes and dries communal items such as towels and linen and health care assistants wash personal resident items. There is dirty and clean separation in the laundry. The staff were able to describe procedures including soaking and washing of soiled and/or infectious linen.There are material data sheets available for all chemical products used for cleaning and the laundry. The owner/manager monitors the cleaning and laundry service through the internal audit programme and on a day to day basis to ensure resident and relative satisfaction is maintained.Relatives interviewed confirm satisfaction with the cleaning and laundry services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | There is an approved evacuation plan and this is displayed and current. Emergency drills take place at least six-monthly. Training is provided around emergencies and security from a health, safety and reporting perspective annually.In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare battery lights, a gas barbecue, linen, continence products, torches and batteries, water, gas heaters, and a gas stove. Food dry stock and frozen food is available. An electric call bell system is available throughout the service and those randomly trialled were operational on the days of audit. The call bells in the dementia unit are able to be heard and identified by staff. An improvement is required to water in the event of an emergency. Security is maintained. The dementia unit is secured with key pad entry. A perimeter fence is erected and is locked. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately. The owner/manager, person on call or emergency services can be contacted if staff are concerned or if an emergency occurs.The potential owner confirms that there are no changes expected to emergency procedures.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms have an external window that can be opened for ventilation. The buildings are ventilated by opening windows and doors. There are heaters which keep all rooms warm. The rooms were heated appropriately on the days of audit. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The owner/manager is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. The service uses an external consultant to guide service delivery. A documented role description for the ICC including role and responsibilities is in place. The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrate an understanding of the infection prevention and control programme. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The organisation has documented policies and procedures in place that reflect current best practice. These are developed by an external consultant. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education uses information provided by the external consultant. External contact resources include GP, laboratories and specialists in the district health board. Staff interviewed confirm an understanding of how to implement infection prevention and control activities into their everyday practice. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The owner/manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided. Information gathered is clearly documented in the infection log maintained by the owner/manager who is the ICC. Surveillance for infection is 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 are investigated and appropriate plans of action are sighted in staff meeting minutes. The surveillance results are discussed in the meeting. \When infections were sighted as occurring in files reviewed, these were checked in surveillance data. All were recorded and data used to review outcomes both for the individual and the facility. The general practitioner confirms they are informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a restraint minimisation policy. This includes methods for ensuring that restraint is not used unless there is an emergency in which case an incident form would be completed. Definitions of restraint and enablers are consistent with this standard. Records sampled confirm that staff actively work to manage any challenging behaviour. Restraint is not used in the service and there are no residents requiring the use of enablers on the days of audit. All staff have completed training around restraint in 2017. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7Advance directives that are made available to service providers are acted on where valid. | PA Low | The policy around advanced directives states that only a competent resident can make an advance directive. Of the five resident files reviewed, one is correctly documented with the general practitioner determining a lack of competence to complete the directive further.  | Four of five resident files reviewed have an advance directive signed by the enduring power of attorney or family and one identifies the resident as being competent to make a decision (note that the resident had been admitted to the dementia unit when the advance directive was signed).  | Ensure that only residents deemed competent are able to sign an advance directive. 180 days |
| Criterion 1.2.2.1During a temporary absence a suitably qualified and/or experienced person performs the manager's role. | PA Moderate | Currently the enrolled nurses take on the role as second in charge in the absence of the owner/manager with the owner/manager stating that they are available by email or phone if required. The owner/manager states that the enrolled nurses would ring the general practitioners practice and practice nurses if required in the event that the owner/manager was not able to be contacted.  | There is a lack of registered nurse cover documented should the owner/manager owner/manager be on leave.  | Ensure that there is a registered nurse who is able to oversee the clinical component of care in the absence of the owner/manager. 90 days |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Family members have completed a satisfaction survey in the past however there is no documentation to confirm that results have been collated with a corrective action plan documented if issues or concerns have been documented.  | The family satisfaction survey has not been collated or data analysed.  | Collate information from the family satisfaction survey and develop an action plan with evidence of resolution if required. 180 days |
| Criterion 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | The owner/manager completes reference checks if they consider that there is a need to. Criminal vetting is not completed.  | Criminal vetting is not completed.Reference checks are not routinely completed.  | i) Ensure that any potential staff member has a criminal vet completed.ii) Complete reference checks for potential staff. 90 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | A review of six staff files (including the owner/manager) indicated that performance appraisals were not completed annually and two had not been completed annually in the past. Four of five staff who should have had performance appraisals completed in a timely manner in 2017 did not. Two staff files indicated that the performance appraisals had not been completed annually in the past.  | A review of five staff files who required performance appraisals indicated that the appraisals were not completed annually and two had not been completed annually in the past. | Ensure that all staff have an annual performance appraisal as per policy. 180 days |
| Criterion 1.2.9.10All records pertaining to individual consumer service delivery are integrated. | PA Moderate | Information is held about each resident in a number of files. For each resident, there is a main folder with the assessment; care plan; activities assessments and plan; doctors notes and some other information. There is a separate folder with any allied health notes. There is a bowel book and a separate vital signs recording book with weights also logged in two folders. The progress notes for each resident are in a folder and health care assistants state that they mostly read the progress notes and do not refer to the care plans or other information in other folders. Senior health care assistants interviewed were knowledgeable around interventions required for each resident.  | There is a lack of an integrated file for each resident. Care staff state that they do not read the care plan unless directed to do so.  | i) Provide an integrated file for each resident. ii) Ensure that care staff are familiar with all information for each resident.90 days |
| Criterion 1.3.3.4The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | The health care assistants document in the progress notes at the end of each shift. The enrolled nurses also document in the progress notes with details of each resident completed. There is no evidence that the owner/manager provides oversight of each resident on a regular basis.  | Documentation to confirm that the owner/manager (registered nurse) provides oversight of each resident on a regular basis was not sighted.  | Document evidence that the owner/manager (registered nurse) provides oversight of each resident on a regular basis. 90 days |
| Criterion 1.3.4.2The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Each resident has an interRAI assessment completed in a timely manner. Each resident also has standardized risk assessment tools completed on admission. These include assessments around pain; pressure injuries; mobility; acuity; nutrition; continence; behaviour and others. Not all are reviewed six monthly as per policy.  | Three of five files reviewed for residents who had been in the service for more than six months did not evidence that there were six monthly reassessments completed using standardized assessment tools.  | Ensure that standardized assessment tools are reviewed six monthly as per policy. 90 days |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | Each resident has an assessment, activities plan and documentation of their attendance in activities. The programme is displayed but does not reference individual one-to-one activities. While 24-hour activities plans are documented, these are generalised with minimal interventions documented.  | The activities programme does not reference individual one-to-one activities. While 24-hour activities plans are documented, these are generalised with minimal interventions documented. | i) Reference one-to-one activities in the activities programme. ii) individualise the 24-hour activities plan according to each resident need.90 days |
| Criterion 1.4.7.4Alternative energy and utility sources are available in the event of the main supplies failing. | PA Low | There are 70 litres of water on site for emergencies.  | There is insufficient water on site in the event of an emergency.  | Ensure that there is sufficient water on site in the event of an emergency as per the Civil Defence guidelines. 180 days |

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

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.