# Sprott Care Limited - Sprott House

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Sprott Care Limited

**Premises audited:** Sprott House

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

**Dates of audit:** Start date: 19 October 2017 End date: 20 October 2017

**Proposed changes to current services (if any):** This audit included verifying the service as suitable to provide medical level care as part of their current hospital certification. Since the previous audit the facility has applied for and been granted permission to increase the dementia unit by one bed from 24-beds to 25-beds. However, this bed has not yet been commissioned.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 86

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Sprott House provides rest home, hospital and dementia level care for up to 98 residents. There were 86 residents on the day of the audit.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

This audit also included verifying the service as suitable to provide medical level care under their current hospital certification.

Sprott House has a general manager who is responsible for operational management of the service. She is supported by a large management team including a clinical services manager, finance and administration manager, support services/village coordinator and a quality manager.

There is a quality and risk management programme that includes analysis of incidents, complaints and an implemented internal audit schedule. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues. Residents and family members interviewed spoke highly of the services provided at Sprott House.

This audit identified an improvement required around aspects of care planning documentation.

The service is commended for achieving a continued improvement rating around good practice.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Sprott House endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Staff demonstrated an understanding of residents' rights and obligations. Staff training is provided on resident rights including advocacy services. Written information regarding consumers’ rights is provided to residents and families. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Sprott House has a current business plan and a quality assurance and risk management programme that outlines objectives/goals. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to staff meetings and quality/health and safety meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Sprott House has job descriptions for all positions that include the role and responsibilities of the position. There is a two-yearly in-service training programme that has been implemented and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

Care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are current and reflect the outcomes of risk assessment tools and written evaluations. Families and residents participate in the care planning and review process. The occupational therapist/lifestyle support manager and recreation assistants provide an activities programme for the residents in the rest home, hospital and dementia care units. The programme is varied and interesting, and meets the recreational needs and preferences of the consumer group. Medication policies reflect legislative requirements and guidelines. Medication management includes the use of an internet based electronic medication system. Registered nurses, enrolled nurses and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three monthly. An external contractor is contracted to provide the food service. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes and special dietary requirements are met. All meals are prepared on-site. There is dietitian review of the menu.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building holds a current warrant of fitness. There are adequate toilets and showers for all units. A number of resident rooms include single ensuites. Fixtures, fittings and floorings are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are done on-site and are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is available. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility has is well laid out and the temperature is comfortable and constant. Residents and family interviewed are very satisfied with the environment.

## Restraint minimisation and safe practice

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

Sprott House has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. At the time of the audit there were two residents with enablers (one bedrail and one lapbelt) and eleven restraints (ten bedrails and one fallout chair with a lap belt). Staff have received training on restraint minimisation and the management of challenging behaviours. All restraint processes including required documentation is completed.

## Infection prevention and control

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

The service has infection control policies and an infection control manual to guide practice. The infection control programme is monitored for effectiveness and linked to the quality risk management plan. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all 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 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 1 | 99 | 0 | 1 | 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](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 Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with 14 care staff, including six caregivers, four registered nurses (RN), three enrolled nurses (EN) and one recreational coordinator, reflected their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Sprott House has policies and procedures relating to informed consent and advanced directives. Ten files reviewed included signed informed consent forms for information sharing, ADLs, mobility assistance, displaying the resident name on their door, taking of photographs, collecting health information and outings as part of the admission process and agreement. There is a resuscitation form and process. Resident files reviewed had completed resuscitation documentation. There were admission agreements sighted, which were signed by the resident or nominated representative. Discussion with ten families identified that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held every three months. Quarterly seasonal newsletters are provided to residents and relatives. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The general manager maintains a record of all complaints, both verbal and written, by using a complaint’s register. Four complaints made in 2016 and six complaints received in 2017 year-to-date have been reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution demonstrated that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed are followed-up and implemented. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The clinical services manager, unit/care managers, RN’s and EN’s discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Thirteen residents (nine rest home and four hospital level) and six relatives (four hospital and two dementia care) interviewed reported that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. Staff have received training around abuse and neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there were no residents that identified as Māori living at the facility. Māori consultation is available through the documented iwi links and Mana Whenua, which is provided through Māori staff who are employed by the service. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. Residents and relatives interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. A formal quality improvement programme has been developed, which includes identification through to sign off. There is a two-yearly in-service training programme that has been implemented and staff are supported to undertake external training. Staff development occurs by way of education and in-service training. Care staff are supported to complete a literacy programme and Careerforce aged care qualifications.  The clinical services manager and quality manager are both Careerforce assessors. The general manager and the clinical services manager attend training sessions appropriate for their positions. Services are provided at Sprott House that adhere to the Health and Disability Sector Standards. There is an implemented quality improvement programme that includes performance monitoring. There are implemented competencies for caregivers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member’s health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. An introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. This booklet is included in the enquiry pack along with a new resident’s handbook providing practical information for residents and their families. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Sprott Care Limited (Sprott House) provides rest home, hospital and dementia level care for up to 98 residents. Seventy-three beds are dual-purpose rest home/hospital level. The dementia care unit has 25 beds though one of the bed spaces (approved by the MoH) has not yet been converted into a resident room.  On the day of audit, there were 36 rest home residents including one resident on respite, 26 hospital residents, including one resident on a mental health contract. There are 24 residents in the dementia care unit, including one resident on a mental health contract. All residents were under the age related residential care (ARRC) agreement. There were no residents under 65 years of age.  This audit also included verifying the service as suitable to provide medical level care.  Sprott House Trust is a not-for-profit organisation governed by a board of trustees. Sprott Care Limited is incorporated as the Trusts operating company. Sprott House Trust and Sprott Care Limited, taken together, are a charitable institution with a continued focus on aged care. The trustees employ a general manager, who is the director of Sprott Care Limited and is responsible for the operation of the residential service and the 13 villas on-site. The general manager attends board meetings and provides management and clinical information to the board of trustees.  There is a strategic and business plan covering 2016 to 2019, which identifies the philosophy of care, mission statement and business objectives/goals and the values of the trust and the risks identified by the management team and the board. The board of directors, general manager and management team review the strategic and business plans as required, and the quality risk management plan 2017- 2020 annually. Quality goals for 2017 include improved information exchange through updating the facility website and introduction of an electronic medication system.  The general manager has been with the service nine years and is supported by a clinical services manager, finance and administration manager, support services/village coordinator and a quality manager. The clinical services manager is supported by two care managers (one role was vacant on the day of the audit), a unit manager and a lifestyle support manager.  The general manager and clinical services manager have maintained at least eight hours annually of professional development related to managing a rest home/hospital/dementia care service. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The clinical services manager steps in when the general manager is absent. The clinical services manager is supported by the quality manager, support services/village coordinator, and the finance and administration manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality risk management plan in place that is reviewed annually. Quality and risk performance is reported across the facility meetings and also to the Trust Board. Facility meetings include full facility (staff), management, quality clinical, health and safety/infection control and wing meetings. Meeting minutes sighted evidence there is discussion around quality. Staff interviewed (seven caregivers, three RNs and three unit/care managers) state they are well informed and have ready access to meeting minutes. General manager monthly reports to the board of trustees provide a coordinated process between service level and organisation.  There are monthly accident/incident benchmarking reports completed by the quality manager that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents. Implemented external benchmarking with Healthcare Help commenced at the beginning of 2017.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Discussion regarding policy development/revision occurs at meetings. Release of updated or new policy/procedure/audit/education occurs across the facility (sighted). Review of policies and documentation occurs on a two-yearly basis. There is an internal audit programme. Audit summaries and action plans are completed where a non-compliance is identified. Issues are reported to the appropriate committee (eg, quality). The service is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided via graphs and internal benchmarking reports.  The quality manager/health and safety officer (non-clinical) shares the health and safety role with the clinical services manager/RN. The health and safety officer (quality manager) has completed external health and safety training and attends the district health board (DHB) risk management group meetings. Each wing has two health and safety representatives. All representatives have attended health and safety training. The health and safety committee meet three-monthly. The meeting minutes evidence trends and analysis of accidents/incidents. The hazard register is current. The health and safety policies have been reviewed to reflect current legislation. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. There is an annual satisfaction survey last completed in November 2016. Overall results report that residents and relatives are satisfied with the service. |
| 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 accident/incident policy, which is part of the risk management and health and safety framework. The service collects incident and accident data and reports monthly to the health and safety officer, clinical meetings and the three-monthly health and safety committee. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted. Twelve accident/incident forms (five rest home, three hospital and four dementia care) were reviewed for August, September and October 2017. All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk.  Neurological observations had been completed for unwitnessed falls and any known head injury. Next of kin had been notified for all incidents/accidents as per written instructions for notification of accident/incidents. The caregivers interviewed could discuss the incident reporting process. The clinical services manager investigates reviews, and implements corrective actions as required. The general manager interviewed could describe situations that would require reporting to relevant authorities. There has been one section 31 notification reported to HealthCERT since the last audit, in relation to a police investigation in August 2017 which is currently ongoing. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. The register of nursing practising certificates and allied health professionals is current. Ten staff files were reviewed (one quality manager, one unit manager, one care manager, two RNs, four caregivers and one recreational assistant). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. Staff complete competencies relevant to their roles.  Care staff are supported to complete a literacy programme and Careerforce aged care qualifications. The clinical services manager and quality manager are both Careerforce assessors. Nursing staff are supported to attend external education. Eight out of ten RNs have completed their interRAI training with two RNs currently in the process of completing their interRAI training. The staff training plan has been changed to monthly full study days that cover the two yearly mandatory training requirements. Other training provided on-site includes moving and handling (physiotherapist) and medication (pharmacist). All nursing staff, caregiver team leaders and activities personnel have current first aid certificates.  All 14 caregivers who work in the dementia care unit have completed the dementia unit standards. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager and the clinical services manager are on duty during the day Monday to Friday. The clinical services manager shares the on-call requirement for clinical concerns with the lifestyle support manager, two care managers and a unit manager. The general manager is on duty for any operational or facility concerns. There are two qualified nurses on duty 24-hours a day, seven days a week. Residents and relatives state there were adequate staff on duty at all times. Staff state they feel supported by the clinical services manager and general manager who respond quickly to after-hours clinical or facility concerns.  The facility is split up into three wings, the West wing, North/Rennie wing, and Duncan Lodge (dementia care) wing.  In the West wing there are 32 rooms with capacity for 34 residents (two are double rooms catering for couples). There were 30 residents in total; 7 hospital and 23 rest home residents. There is a care manager who is supported by one RN or EN on the morning, afternoon and the night shifts. The nurses are supported by six caregivers on the morning shift, five on the afternoon shift, and two on the night shift.  In the North/Rennie wing there are 34 rooms with capacity for 39 residents (five are double rooms catering for couples). There were 32 residents in total - 18 hospital and 14 rest home residents. There is a care manager (role currently vacant) who is supported by one RN or EN on the morning, afternoon and the night shifts. There are six caregivers on the morning shift, five caregivers on the afternoon shift, and three caregivers on the night shift.  In the Duncan Lodge dementia care wing there is the potential for 25 rooms though one of the rooms has yet to be commissioned; on the day of the audit the wing was full with 24 residents. There is a unit manager (RN) who is supported by one EN on the morning shift. The RNs available in the facility cover the afternoon and night shifts in the dementia wing. There are five caregivers on the morning and afternoon shifts, and two caregivers on the night shift  . |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. |
| 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 | There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the Code of Consumer Rights, complaints information, advocacy, and admission agreement. Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are evidenced in the resident files sampled. The admission agreement reviewed aligns with the ARC contract and exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| 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 | Twenty medication charts were reviewed (six hospital, six dementia and eight rest home including one respite). There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of monthly robotic packs is completed by the night RN and any errors fed back to pharmacy. Registered nurses and enrolled nurses who administer medications have been assessed for competency on an annual basis. The service uses an electronic medication system. Education around safe medication administration has been provided. Medications were stored safely in all units (rest home, hospital and dementia care).  Medication fridges are monitored weekly and evidenced to be within acceptable range. All eye drops and creams in medication trolleys were dated on opening. There are no standing orders in use. Verbal order forms are available. The main medication room with controlled drugs safe and medication fridge is in the hospital wing. There is evidence of weekly stocktakes of controlled drugs and six-monthly pharmacy audits. There were three self-medicating residents in one unit on the day of audit. All self-medicating residents had competencies checked and signed three monthly by the GP. The effectiveness of ‘as required’ medications is entered into the electronic medication system. Medication charts sampled were reviewed three monthly by the attending GP.  The service implemented an electronic medication system as a quality initiative. The intent was for having a simpler, safer process for medication management. The decision to do so was driven by the desire to minimise the risk of errors and so that accurate, relevant, on-time documentation would be maintained. The process started in February 2016 and was completed and integrated into our practice by November 2016. The system is now fully integrated into our practice and weekly checks have ‘ironed out’ most of the post-implementation issues (e.g. correct prescribing such as indication for use for medication). These checks are ongoing. As a result of this initiative, on-time, at-the-time documentation has improved with a lower margin for error. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Meal services provided at Sprott House are contracted to a catering company. There is a head chef/site manager with support from a second chef and kitchenhands on duty daily. The kitchen staff have completed food safety training. All food is prepared and cooked on the premises. There is a six-weekly winter and summer menu that has been reviewed by a dietitian. The menu includes resident choice. The chef receives dietary requirements forms for each new resident admission with documented nutritional needs, likes and dislikes. Vegetarian, gluten free and modified/soft/pureed meals are provided. Alternative meals are offered as required.  Sandwiches and nutritious snacks are delivered to the dementia unit daily. The kitchen is notified of any dietary changes, special requirements and any residents with weight loss. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Chemicals are stored safely. Residents and the family members interviewed were very happy with the quality and variety of foods. The kitchen can cater for one extra resident in the dementia unit. The kitchen met requirements but required maintenance in several areas. Plans were sighted, and renovations are planned early in the New Year. |
| 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 service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to potential residents is recorded and communicated to the potential resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RNs complete an initial assessment on admission including (but not limited to); a) continence, b) pressure area risk assessment, c) nutrition d) falls risk assessment, e) pain assessment, f) behaviour assessment and monitoring as appropriate. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes for long-term residents under the ARCC. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. The long-term care plans reflect the outcome of the assessments. The general practitioner completes a medical admission within two working days. All residents interviewed were satisfied with the support provided. Assessment process and the outcomes are communicated to staff and assessment tools link to individual care plans. Residents and families advised that they are informed and involved in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Residents’ long-term care plans reviewed were resident-focused and individualised. Hospital and dementia care plans reviewed, all documented the required supports/needs to reflect the resident’s current health status. However, in the rest home files reviewed not all interventions supported all identified needs. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans.  Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan. Examples sighted are cares required for wounds, infections, changes to medication, and catheter. Ten resident files reviewed identified that family were involved. There was evidence of allied healthcare professionals involved in the care of the resident. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Care plans are goal orientated and reviewed at six monthly intervals or when a resident's condition alters. The RN initiates a review and if required, GP or nurse specialist consultation. Care plans are updated to reflect intervention changes following review or change in health status as evidenced in seven of nine files sampled. Family notifications are documented on the contact with family member record page held within the resident file. Adequate dressing supplies were sighted. Wound management policies and procedures are in place.  A wound assessment and wound care plan (includes dressing type and evaluations on change of dressings) were in place for 15 residents (five rest home, four dementia and six hospital) and 21 wounds (twelve skin lesions, four skin tears, one ulcer and four other). There is access to a wound nurse specialist and district nurses for advice for wound management. Continence products are available. The residents’ files include a urinary continence assessment, bowel management plan, and continence products used. The RNs interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Continence management in-services have been provided. Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required.  Pain management is reviewed at the resident reviews with the MDT team. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours. During the tour of facility, it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation. All falls are reported on the resident accident/incident form and reported to the RN and unit/care manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. Sprott House has a champion palliative care nurse who works closely with hospice, staff, residents and families to provide quality end of life care. A physiotherapist referral is initiated as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A lifestyle support manager who is a trained occupational therapist is employed full time to coordinate the activities programme for all residents. She is supported by three activities officers who provide a separate programme for each wing. The activities team meet weekly to plan the programme, and monthly with the clinical services manager. There is a main programme with shared activities open to all residents (as appropriate). Each unit has specific programme activities that are appropriate to the resident’s physical and cognitive needs. Residents in the dementia unit have plans that include activities to manage behaviours over the 24-hour period and dementia staff provide activities when activities staff are not present. There is one-on-one time with residents evidenced in the individual monthly activity progress notes.  Community links include an adopt-a-grandparent scheme with a local school. Returned Services Association (RSA) members visit residents on a regular basis. Volunteers visit in the weekends and spend time with residents. Mobility taxis are used for outings. The activity person makes contact with a resident and their family/whānau within 24 hours of admission. Their activity care plan is developed within three weeks of admission in consultation with the resident/family/whānau and reviewed six-monthly with the long-term care plan. Attendance sheets and individual monthly progress notes are maintained. Feedback on the programme is received through monthly resident meetings and regular surveys. Residents interviewed (eight rest home and four hospital) overall reported that they enjoyed the activities on offer. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In files sampled, all initial care plans were evaluated by the RNs within three weeks of admission. The long-term care plans reviewed were evaluated at least six monthly or earlier if there was a change in health status in five of five files sampled (one was a respite and four residents had not been at the facility for six months). There is at least a three-monthly review by the GP. Overall changes in health status were documented and followed up (link 1.3.5.2). Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. Referral forms and documentation are maintained on resident files as sighted (dietitian). |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies in place for waste management, waste disposal of general waste and medical waste management. There are approved sharps containers in use for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals in use are stored securely on the cleaner’s trolley. Laundry and sluice rooms are locked when not in use. Material safety datasheets are available in all key areas. The hazard register identifies hazardous substances. Gloves, aprons, and goggles are available in key areas for staff. Staff receive education on chemical safety. Interviews with caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Sprott House provides rest home, hospital and dementia care in wings within the same facility. The service displays a current building warrant of fitness which expires on 18 July 2018. There are several communal areas provided for both groups and individuals. There is secure access to the dementia unit with various quiet spaces for residents and families to enjoy time together including a baking corner and a secure sensory garden/courtyard. Hot water temperatures checks are conducted and recorded monthly by the maintenance person. Hot water temperatures are recorded in rotating locations throughout the facility monthly; where temperature were above the 45 degrees, corrective actions have been initiated. The service utilises hoists for resident transfer, these are calibrated and have electrical checks annually (last done August 2017). There is sufficient medical equipment to meet resident needs, including pressure relieving mattresses, shower chairs, wheelchairs, walking frames, hoists, heel protectors, transferring aids, chair scales, blood pressure machine and thermometers.  All medical equipment has been calibrated by an authorised technician (August 2017). Electrical equipment has been checked and tagged (August 2017 and October 2017). There is a large communal lounge with sufficient space and seating for individual and group activities, chapel, dining areas, activities lounge, a conservatory, a library and small sitting areas. There are sufficient communal toilets adjacent to the lounge and dining areas. Many of the resident rooms also have ensuites. There are several quiet seating nooks throughout the facility providing quiet, low stimulus areas and privacy for residents and visitors. Residents were observed to safely mobilise throughout the facility. There is easy access to the outdoors. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with six caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | The service has a combination of single rooms with shared bathroom facilities (North wing) and several rooms throughout the facility with their own full ensuites (Duncan Lodge, Rennie wing and West wing). The Rennie wing has larger rooms that can accommodate couples. There are two double rooms that had married couples sharing at the time of audit.  The number of visitor and resident communal toilets provided is adequate. Facilities were viewed to be kept in a clean and hygienic state. Regular audits of the environment are completed as per the quality programme. Residents interviewed state their privacy and dignity are maintained while attending to their personal cares and hygiene.  Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs and are sufficient to meet the needs of the resident. |
| 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 | The rooms including the additional room in the dementia unit are quite spacious and meet the assessed resident needs. Residents can easily manoeuvre mobility aids around the bed and personal spaces. The bedrooms are personalised. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient space to allow cares to take place and staff were seen to use hoists. Residents interviewed are very happy with their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are lounge and dining rooms in each unit, a conservatory in the dementia unit which is large enough to include the additional room in the dementia unit (when this is converted to a resident room), small seating areas and a large communal activities room. The dining areas are spacious and are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Sprott House has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the laundry staff. Staff attend infection control education and there is appropriate protective clothing such as aprons and gloves available. There are dedicated laundry and cleaning staff. Manufacturer’s data safety sheets are available. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning audits are conducted. Internal audits and resident satisfaction surveys identify any areas for improvement. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. Fire evacuation drills take place every six months, with the last fire drill occurring on 6 October 2017. The NZ Fire Service approved the evacuation scheme on 26 March 2010. Sprott House has a Memorandum of Understanding with St John of God and Huntleigh Home and Hospital to provide mutual assistance in the event of disaster. Smoke alarms, sprinkler system and exit signs are in place. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Emergency equipment is available. The service has alternative gas facilities (BBQ and gas hobs in the kitchen) for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup.  Civil defence boxes are available in each wing (sighted) and are checked six monthly. There are four civil defence cupboards and the emergencies supplies are checked annually. The heating is via a gas boiler. There is food stored in the kitchen for three days. There is more than sufficient water stored (22,000 litres) to ensure for three litres per day for three days per resident. The staffing level provided adequate numbers of staff to facilitate safe care to rest home, dementia and hospital level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign-in when visiting the facility. There is a RN on-site available to all residents 24 hours per day, seven days per week. |
| 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 communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed state the environment is warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The role of the infection prevention and control (IPC) coordinator is held by the quality manager who has a bachelor of science in public health and a master of sciences in tropical medicine and has been at the service for seven years. He is supported in this role by the clinical services manager (an RN) who has overall responsibility for the facility IPC. The IPC team also includes two staff from each of the four wings and from housekeeping, RNs, administration, food services, recreation, support services, clinical services (a total of 18 representatives). The IPC coordinator is a member of the CCDHB infection control team. The IPC coordinator can access external specialist advice from GPs, laboratories and DHB IPC specialists when required. The IPC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and management team and external expertise when required.  Infection control is a standing agenda item at the monthly staff meetings and quality meetings (minutes viewed). Staff are informed about IPC practises and reporting. They can contact the IPC coordinator 24/7 if required and concerns can be written in progress notes and in the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IPC coordinator and entered in the infection register. There is a job description for the IPC coordinator including the role and responsibilities of the position. Infection control is part of the audit schedule and is undertaken monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The quality manager is the IPC coordinator. Infection control matters are taken to all staff and quality meetings (minutes reviewed). The IPC coordinator can access external DHB, IPC nurse specialist, laboratories, and GPs specialist advice when required. He has the main responsibility for reviewing the IPC programme annually. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GPs is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | Sprott House has infection control policies and an infection control manual, which reflect current practise. The IPC programme defines roles and responsibilities of the IPC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IPC coordinator. The IPC programme is reviewed annually by the IPC coordinator and the quality committee who can access external specialist advice to do this. Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The IPC coordinator is the quality manager who has undertaken specialist IPC training. The IPC coordinator attends CCDHB IPC training and update sessions every three months. All new staff receives infection control education at orientation including hand washing and preventative measures. Annual infection control education occurs. The training folder records the staff education and attendance. External resources including DHB, laboratories and GPs ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the flu vaccine. There have been no outbreaks since the previous audit, however, there is an understanding of outbreak management evidenced in RN and caregiver interviews. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The quality manager uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the quality manager. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality oversight committee meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices.  The infection control programme is linked with the quality management programme. Results of infection control data collated is graphed and discussed at staff and wing meetings. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Infection control is internally benchmarked which continually compares infection control data gathered. Quality improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Sprott House has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. Forms include a restraint and enabler register, a restraint assessment form, a restraint and an enabler consent form and a restraint and enabler monitoring form. At the time of the audit there were two residents with enablers (one bed rail and one lap belt) and eleven restraints (ten bed rails and one fall out chair with a lap belt). Staff have received training on restraint minimisation and the management of challenging behaviours. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is the ‘lifestyle support manager’ who is a registered occupational therapist and who has been in the role for over five years. There is a restraint coordinators job description. The approved restraints (bed rails, lap belts and fall out chair) are documented in the restraint policy. Restraint and consent is in consultation/partnership with the resident (as appropriate) or family member, the restraint coordinator, GP and an RN. There is provision for emergency restraint following consent from family. Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint.  Alternative strategies are documented on the behaviour chart of a resident with challenging behaviour. Staff complete incident forms and report any accidents/incidents to the RN/restraint coordinator in regard to restraint use and these are discussed at the RN and management meeting and corrective actions initiated. Frequent fallers are identified through the accident/incident data collated. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessments are undertaken by the restraint coordinator or RN in partnership with the resident and their family and the resident’s GP. Restraint assessments are based on information in the initial care assessment, long-term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form, and this is completed in consultation and discussion with the resident/family and GP. Three of three resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three-monthly evaluations. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or family/whānau, the facility restraint coordinator, and the resident’s GP. Restraint use is reviewed three monthly in the facility restraint meeting and also as part of monthly restraint register reviews.  Any restraint incidents/adverse events are discussed at this meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. On interview the restraint coordinator stated that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented, and the use of restraint evaluated. This identifies the frequency of monitoring and was evidenced as being implemented. Care plans reviewed of three of three hospital residents with restraint identified observations and monitoring. Eleven residents who have restraints are entered in the restraint register. Two residents with enablers are entered in the enabler register. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Written evaluations are completed by the restraint coordinator at least three monthly or earlier if required. Families are included in restraint review as part of the long-term care plan review. Effective de-escalation strategies are reviewed by the restraint coordinator and restraint committee. Individual restraint use is monitored and recorded by care staff. The policy clearly states the timeframes for monitoring with a minimum of two hourly checks overnight when bedrails are in situ. Evaluation timeframes are determined by risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Individual approved restraint is reviewed at least three monthly as part of the medical review and six monthly as part of the long-term care plan review in consultation with the resident/family/whānau as appropriate. Restraint usage is monitored regularly by the restraint coordinator. Incident/accidents are reviewed by the restraint coordinator. Corrective actions are monitored. There is a monthly restraint coordinator report (including the hours of restraint). Restraint is discussed at all clinical and management meetings. Issues/concerns are discussed at the meetings (minutes sighted). |

# 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 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Care plans link to interRAI assessments and other assessment tools. Care plans also evidence integrated care. Care plans are goal orientated and reviewed at six monthly intervals. Seven of eight care plans reviewed were updated to reflect intervention changes following review or change in health status. | One care plan (rest home) identified the resident was on warfarin (on return from a hospital admission). The care plan had been updated to include the medication but did not have the risks associated with this medication documented, (this was addressed on the day of audit). One rest home resident (tracer) with a documented instance of wandering off-site did not have interventions documented for this behaviour | Ensure that interventions to manage assessed risks are updated in the resident’s care plan to support the residents identified health needs.  90 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Sprott House is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified. One quality initiative included continuous improvements to North Wing environment to enhance engagement and social interaction with residents in their surroundings. They have created ‘Pod’ areas which have improved resident communication both with staff and other residents and their families. There is more opportunity for small group sessions and one-to-one interaction. Space has been created to accommodate resident preference. Focus has changed to create a home environment rather than a clinical setting (having chairs ‘lined up’ around the lounge area. Created a smaller dining area within the wing for the more independent residents to socialise with each other. They provided staff education in the North wing to assist staff to focus on a sensory environment to promote person centred care and engagement. This new initiative is a ‘follow on’ from a successful initiative in their dementia unit, tailored to the needs of rest home and hospital residents in the North Wing. On evaluation they determine; there has been an increase in positive feedback from residents and families. Engagement of staff with residents has improved and the social interaction of residents has improved. | The service continues to implement quality initiatives. One of their quality goals was around identifying link nurses to oversee palliative care, wound care, and continence management. Example; Their goal was to enhance capabilities of nursing staff when providing end of life care. They identified a champion nurse with specific interest in palliative care to support all staff in providing quality end of life care to residents. They released the registered nurse to actively work with the hospice to gain experience in palliative care nursing and interventions. The RN attends regular meetings with the Mary Potter palliative care team. Shares this information with all staff during various staff meetings to ensure best practice is maintained. Their designated palliative care champion works across all wings when end of life cares are needed to support and educate staff and family members. Feedback from the families has indicated that the investment has been successful at taking them through this difficult time |

End of the report.