

Graceful Home No.2 Limited - Shelly Beach Dementia

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 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](#).

The specifics of this audit included:

Legal entity: Graceful Home No.2 Limited

Premises audited: Shelly Beach Dementia

Services audited: Dementia care

Dates of audit: Start date: 15 January 2018 End date: 15 January 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 8

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Graceful Home No.2 Limited - Shelly Beach Dementia provides dementia level care for up to 14 residents with an occupancy of eight on the day of the audit.

This certification audit was conducted against the relevant Health and Disability Standard and the contract with the District Health Board. The audit process included an interview with the director/manager, review of policies and procedures, review of resident and staff files, observations, and interviews with family, management, staff and one resident.

Improvements are required to documentation of some aspects of documentation of staff recruitment; the call bell system and completion of an annual review of the infection control programme.

Consumer rights

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

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

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

The organisation's philosophy is documented. There is a current business, quality and organisational risk management plan. Quality and risk management systems support service delivery and include internal audits, complaints management, surveillance of infections and incident/accident management. Quality and risk management activities and results are shared among staff and family.

Human resource policies include documentation of some recruitment information. Staff complete an orientation programme and there is regular staff training and development. Staffing levels meet occupancy and acuity levels and family state that their family member is well cared for and safe.

Resident records are integrated and maintained in a secure manner.

Continuum of service delivery

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

The nursing team is responsible for the development of care plans with input from staff and family/whanau representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and DHB requirements. 24-hour activity plan and diversional care plans are in place.

Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, family/whanau expressed satisfaction with the activities programme in place.

A medication management system is in place and medication is administered by staff with current medication competencies. All medications are reviewed by the GP every three months.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. Snacks are provided to residents throughout the day and night if needed.

Safe and appropriate environment

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

The facility has a current building warrant of fitness. The facility has a communal lounge and dining area with a secure outdoor area. The building, facilities, furnishings and equipment are maintained and suitable for people identified as having dementia. Electrical equipment is tested, and medical equipment calibrated as per policy in a timely manner. The facility has plenty of natural light and is maintained at a comfortable temperature.

Essential emergency and security systems are in place with emergency drills completed at least six monthly. Call bells allow residents to access help when needed.

Restraint minimisation and safe practice

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

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in restraint, challenging behaviours and de-escalation techniques through in service trainings. Five out nine health care assistants completed level four dementia course and others are still pending.

Infection prevention and control

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

Infection control and prevention 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.

Infection data is collected, analysed monthly and reported to staff and management in a timely manner. Infection control surveillance and associated activities are appropriate for the size and complexity of the service. An improvement is required to ensure the infection control programme is reviewed and annual report completed at the end of each year.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	2	1	0	0
Criteria	0	90	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Care staff interviewed all demonstrated knowledge and understanding of resident rights, obligations and how to incorporate them as part of their everyday practice. Staff address residents with respect, knocking on doors, asking to enter rooms prior to entering and providing residents with choices. Staff interviewed understand consumer rights and are aware of consumer rights legislation. Training in the Code of Health and Disability Services Consumers` Rights (the Code) has been provided in 2017.
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	Residents and their families are provided with all relevant information on admission to the facility. Informed consent is gained with signed documentation held on individual files. Advance directives are documented by the general practitioner with family wishes taken into consideration. The general practitioner makes a clinically based decision as there are no residents deemed competent. Discussions are held with residents and family give informed consent, choice and options on an on-going basis. Interviews with relatives confirm the service actively involves them in decisions that affect their family members' lives.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Policies and procedures require that residents are informed of their right to access independent advocates. This is identified in the resident agreement with family having a key role in being informed. Contact numbers for advocacy services are displayed and family members interviewed confirm that they understand these rights and their entitlement to have the support person of their choice available if they choose.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Visitors can visit residents at any time. This was confirmed in interviews with family and observed as occurring during audit days. Access to the community is supported with family encouraged to take their family member home or out into the community. Staff also take residents out into the community for walks and to engage in community activities when possible with access to the community used as a strategy for some residents to de-escalate behaviours that challenge.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has appropriate systems in place to manage complaints. Policies and procedures on complaints management meet the requirements of the Code. The registered nurse reports that there have been no external complaints to the Health and Disability Commissioner, the district health board or from other external agencies since the last audit.</p> <p>Family members interviewed confirm that they have been advised on entry to the facility around how to raise concerns or complaints. An outline of the complaints procedure is also included in the resident agreement. The family interviewed had not had to raise a complaint to date but stated that any suggestions were explored and acted on promptly. A satisfaction survey for newly admitted residents is completed after six weeks with staff ensuring that each family member has had the complaints process explained to them.</p> <p>The complaints register identifies complaints with documentation that confirms that these are resolved in a timely manner. Complaints records include date, name, outcome of the complaint and copies of letters and emails from the complainant. Documentation confirms that complainants are happy with resolution of the complaint. There are few complaints documented with the last being in 2016. A record of compliments is also kept with many family members confirming satisfaction with the service.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	<p>FA</p>	<p>Policies are in place to guide staff actions and ensure residents` rights are discussed. Family communication is recorded in progress notes. A review of resident records indicate that rights are discussed with family members.</p> <p>The Code is displayed throughout the facility. Information about the Code is provided in the admission</p>

rights.		pack and included in the resident agreement. The Nationwide Health and Disability Advocacy Service poster and pamphlets are also displayed in the facility.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' privacy and dignity is respected. This was confirmed in interview with family who expressed a high level of satisfaction with the service. Those interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p> <p>There is an abuse and neglect policy available to staff and staff interviewed understand how to report such incidences if suspected or observed. The registered nurse reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There are no incidents of abuse or neglect documented in the incident forms or in the complaints register. The general practitioner states that there is no evidence of any abuse or neglect.</p> <p>Resident's personal areas are individualised. There is one shared room that is currently not occupied.</p> <p>The residents' preferred name is ascertained on admission, documented and used by staff when addressing residents or family members. Individual values and wishes are considered. This was evident in resident records sampled. Spiritual needs are considered and catered for with church services provided weekly.</p> <p>Family interviewed describe staff who are respectful and who provide an environment that is family orientated.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. Assessments and care plans document any cultural/spiritual needs. Special consideration to cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural training at least two yearly.</p> <p>The owner identifies as Māori and states that the philosophy for all is based on essential parts of Māori culture with the key being respect, caring and family. Care staff interviewed describe how they provide specific care for residents who identify as Māori with this including attention to language, music, activities, food and cultural needs as identified by the resident and/or family. A Māori resident able to be interviewed stated that they still speak te reo with staff who can also speak Māori. They praised the service for the care provided.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Family members interviewed confirm that the resident values and beliefs are actively recognised and well supported. This was confirmed during the audit through observations of interactions between staff and residents. Family report that staff work hard at providing care and support which reflects the resident's individual needs, values and beliefs. Family are asked to be involved in care planning. Family interviewed gave examples of being actively involved in any changes in routine for their family member.</p> <p>Staff interviewed can describe how each resident is able to make choices around activities of daily living and activities. Residents on the day of audit were observed to actively engage in activities of their choice and to be supported to realise their wants as these were expressed. An example was taking a resident for a walk in the community when they indicated that they wanted to go out and providing musical instruments to another resident.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A policy on discrimination was sighted. This includes guidelines for staff regarding the prevention, identification and management of discrimination, harassment and exploitation. The registered nurse reports that the rights of the individual are protected, and interventions occur to ensure a balance between personal rights of the individual and others living and working in the facility. All family interviewed report that they believe their family member is safe at all times.</p> <p>Staff receive training on professional boundaries and code of conduct. The Code of Conduct which includes House Rules is signed by each staff member on entry to the service. Situations which constitute misconduct are included in staff employment agreements.</p> <p>Records of adverse events sampled confirm that there have been no reported allegations of discrimination or exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies and procedures to guide practice. There is a training programme implemented and staff interviewed describe best practice based on policies and procedures. Staff interviewed can also describe changes they have made to practice following attendance at staff training including attendance at conferences.</p> <p>All family interviewed state that each resident receives 'good care and support' with staff conscious of managing any challenging behaviour quickly and effectively.</p> <p>Consultation with key health professionals and services occurs as required for individual residents as sighted in resident records. The general practitioner confirms that they visit the facility at least weekly with each resident having a medical review at least monthly. The general practitioner states that there is good communication between medical staff and the staff in the facility and any instructions are carried</p>

		<p>out in a timely manner. The staff are also noted to inform the general practitioner of any issues as these arise.</p> <p>Health care assistants and the registered nurse can describe practice as per policy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is evidence that the service adheres to the practice of open disclosure. The registered nurse reports that the director/manager is open to management of adverse events with these put in the context of quality improvement. This was evident in adverse event reports and interview with family members.</p> <p>Access to interpreter services is available through the district health board if required. At the time of the audit there are no residents who require an interpreter. Staff are observed to engage with residents in a way that involves them as much as possible. Staff have learned key phrases and words to communicate with two residents who have English as a second language.</p> <p>The residential agreement contains descriptions of the services to be provided for both subsidised and non-subsidised resident. This meets district health board requirements. Resident agreements are signed on entry.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>There is a documented organisational structure, with the sole director being supported by a business partner (accountant) who provides financial support. The director also owns other aged care facilities.</p> <p>The direction, philosophy and business goals are documented. Residents and family are informed of the philosophy with documentation provided during entry to the service.</p> <p>The director is referred to as the director/manager has at least eight hours training annually relevant to the role.</p> <p>The facility can provide care for up to 14 residents requiring rest home - dementia level of care. There are currently seven residents in the service with another resident currently using respite services.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which</p>	FA	<p>Day to day activities are the responsibility of the registered nurse, with the support of another registered nurse who also works across all services owned by Graceful Home No.2 Limited. Both registered nurses are able to provide operational oversight when the director/manager is on leave. The director/manager states that they would always remain in phone contact even if away.</p> <p>Director/manager provides accounting, administration, staffing and overall management of the service with the support registered nurse providing assistance as required. The director/manager is also onsite</p>

<p>ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>during the week with input as and when required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Policies and procedures are documented by an external consultant and there are identified quality indicators for key components of service delivery. Policies reflect the district health board requirements and best practice. Policy reviews are conducted as required and updates circulated to staff. There is a system in place which ensured that the current version of all policies, procedures and work instructions are available to staff. Documents sampled during the audit are controlled and have been approved by the organisation.</p> <p>There is a documented business and risk management plan. Quality indicators are documented with systems in place to ensure that these are met. These are to be reviewed annually noting that the service has been purchased in February 2017.</p> <p>A range of quality activities are implemented, and improvement data is analysed to identify trends. Staff meeting minutes confirm that quality data, and initiatives, are communicated with data discussed. All staff interviewed confirm that they are orientated to the quality and risk management programme.</p> <p>Compliance with requirements is measured through the implementation of internal audits. There is an annual internal audit schedule with audits completed in a timely manner. Audits reviewed for 2017 confirm that any corrective action plans are documented with evidence of resolution of issues also documented.</p> <p>Risk management activities and related risk management plans are documented. Risks have been identified and are being monitored by the registered nurse and reported at staff monthly meetings. Health and safety systems are well implemented.</p> <p>Satisfaction surveys are completed by new residents and/or family members six weeks after entry to the service and annual satisfaction surveys are also completed.</p> <p>Staff complete a wellness survey that also helps to identify any stress or risks.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected</p>	<p>FA</p>	<p>Incident and accident prevention, management and reporting policies/procedures are in place. Incident records sampled confirm that all reported incidents are taken seriously and treated as opportunities for improvement.</p> <p>Emergency actions are implemented in the event of clinically related incidents or incidents related to challenging behaviours and the required clinical observations documented.</p> <p>The registered nurse collates all adverse events. This allows for trend analysis. Results of trends are</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>communicated to staff through the staff meeting and at handover.</p> <p>The director/manager and registered nurses demonstrate an awareness regarding essential notifications. Communication with family members is evident with documentation on incident forms confirming that family are notified of any incident.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Policies and procedures in relation to human resource management are documented.</p> <p>Staff files confirm that each staff member has a job description relevant to their role. Job descriptions outline accountability, responsibilities and authority.</p> <p>A review of annual practicing certificates indicate that health professionals involved with the service (including registered nurses, doctor, pharmacist and podiatrist) have a current certificate.</p> <p>Criminal vetting of staff, a signed employment contract and a record of reference checks is not documented in all staff files reviewed and an improvement is required.</p> <p>The registered nurse reports that all new staff receive an orientation to the facility and to their respective role. Care staff interviewed confirm that the orientation is relevant to their role. A record of orientation is retained on the staff file. Records of completed orientation include the essential components of service delivery, including emergency procedures and health and safety. Staff performance is monitored in an ongoing manner and performance appraisals are conducted annually.</p> <p>A scheduled annual training programme is implemented. There is a signed attendance register for each training session and a log retained of training provided for each staff member. Staff interviewed report that the support and training they received provides them with the skills they need. Health care assistants confirm they are well supported by the registered nurse. Four health care assistants have completed training in dementia and the other three have been appointed in 2017. The three health care assistants identified are yet to enrol in the dementia training but have completed training offered by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service</p>	<p>FA</p>	<p>The service has a total of 11 staff including a registered nurse (20 hours a week) and health care assistants. A registered nurse from another facility provides support currently for 20 hours a week however this will decrease as the appointed registered nurse completes orientation.</p> <p>The documented rationale for determining service provider levels and skill mix is based on occupancy ratios. The registered nurse oversees the roster with the health care assistant ensuring that staff are on duty as allocated.</p>

providers.		The electronic roster was randomly sampled and there are sufficient numbers of staff to cover the 24-hour period. The registered nurse and director/manager are on call 24 hours a day, seven days per week. Staff state that if they ring the registered nurse or director /manager, that they respond immediately.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Resident records are documented with each resident having an individual record. Progress notes are written at each shift by the registered nurse and health care assistants and continuity maintained. All entries included the date, time, name and designation of the writer. Resident records include input from allied health providers and the general practitioner with all information integrated. All records are legible, and the name and designation of the service provider is identifiable. A register of current residents is maintained. All past and present records are stored in a secure and safe manner and are not publicly accessible or observable. Archived records are stored in a safe manner.
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. Shelly Beach Dementia's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided.
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 DHB is utilised when residents are required to be transferred to the public hospital or another service. 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	FA	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner and medication entries sampled on the electronic system complied with

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>legislation, protocols and guidelines. Medications are stored in a safe and secure way in the locked drug trolley and cupboards. The e-prescribing electronic system is accessed by use of individual passwords. Medication reconciliation is conducted by the RNs when the resident is transferred back to service. The organisation uses the electronic system for e-prescribing, ordering, dispensing and administration. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos uploaded for easy identification.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The Health care assistant was observed administering medication correctly.</p> <p>There were no residents on controlled medication or residents self-administering medication at the time of the audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Meal services are prepared on site and served in the allocated dining room. The service employs two cooks; one works six days a week and the other one day a week respectively. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer meal in place.</p> <p>The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the service. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The resident's weights are monitored monthly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is done.</p> <p>The family/whanau interviewed acknowledged satisfaction with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer</p>	<p>FA</p>	<p>The support RN reported that all consumers who are declined entry are recorded 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 consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</p>

and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial assessments are completed within the required time frame on admission while resident centred 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 nursing staff utilise standardised risk assessment tools on admission. In interviews conducted family/whanau 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, integrated and provide continuity of service delivery. The assessed information is used to generate resident centred care plans and short- term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.
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 resident centred care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to the supplies and products they needed.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Activities are appropriate to the needs, age and culture of the residents. The diversional therapist develops an activity planner and daily/weekly activities are posted on the notice board. Resident's files have a documented activity plan that reflects the resident 's preferred activities of choice.24-hour activity care plan is developed for each resident. Activity progress notes are completed daily. Over the course of the audit residents were observed being actively involved in a variety of activities. Family/whanau interviewed expressed satisfaction with the activities in place. Individualised activity plans are reviewed six monthly or when there is any significant change in participation and this is done in consultation with the RNs. The activities vary from art and craft, bingo, music, dancing, bowling van trips, exercises/walking and church services. The diversional therapist reported that they have group activities and also engage in one on one activities with some residents. Activities are modified to varying abilities

		and cognitive impairment. The resident's activities participation log was sighted.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident's centred care plans and activity plans are evaluated in a comprehensive and timely manner. Reviews are fully documented and include current resident's status, any changes and achievements towards goals. Family/whanau, staff input is sought in all aspects of care and are reviewed/evaluated. Short term care plans are developed as per rising need. All care plans sampled were updated and reviewed every six months or as required.
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 utilise 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. All referrals are facilitated by the nursing staff or GP
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	Procedures for the management of waste and hazardous substances are documented. This includes emergency procedures and exposure to chemicals and body fluids. Cleaning chemicals were observed to be kept secure. Staff have access to personal protective equipment including access to gloves, hand sanitizer, aprons and masks. Domestic waste is placed in a skip which is emptied at timely intervals. There have been no reported incidents regarding waste or hazardous substances. Staff training records confirm that staff receive training on the management of waste and hazardous substances as part of training around infection control. Staff last had training in 2017.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that	FA	A current building warrant of fitness is posted in a visible location at the entrance to the facility. The current owner states that there have been no building modifications since the last audit. There is a planned maintenance schedule implemented with the maintenance staff completing maintenance as required. Staff identify any issues and inform the registered nurse or director/manager directly. These are addressed by the director/manager with staff stating that this occurs in a timely

<p>are fit for their purpose.</p>		<p>manner. The director/manager is on site weekly and available by phone at any time with maintenance issues addressed as these arise.</p> <p>The areas are suitable for residents with mobility aids and there is a ramp at the back door that enables access for people with mobility issues. The perimeter fence is secure with this strengthened because of one resident previously trying to scale the fence. There are two garden areas with outdoor seating and shade.</p> <p>Electrical safety testing occurs annually, and all electrical equipment sighted has an approved testing tag. Clinical equipment is tested and calibrated by an approved provider annually with records confirming this.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Toilets and bathrooms are accessible for residents. Bathrooms and shower rooms are maintained in line with infection control requirements. Toilet and bathroom facilities can accommodate equipment if required. Hot water is maintained at a consistently safe temperature. Family members interviewed voiced no concerns regarding the toilet/bathing facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Each room is for an individual resident apart from one bedroom (currently not occupied) that has two beds in it.</p> <p>All bedrooms have at least one external window/door. All rooms have personal furnishings. The family members interviewed state that they have no concerns regarding personal space/bed areas.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>There is a furnished lounge and dining area which can comfortably accommodate all residents. Residents are also able to sit outside if they choose to have meals with picnic tables and umbrellas well used on the day of audit. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>

<p>safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>The dining lounge areas are suitable for activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Cleaning and laundry guidelines are documented. Staff interviewed can describe processes as per policy.</p> <p>All personal laundry is completed on site. The laundry is locked when not in use as laundry chemicals are kept in the cupboard. There is a defined process for the management of clean and dirty linen with staff able to describe how the laundry is kept separate.</p> <p>Health care assistants undertake laundry and cleaning duties as part of their daily work.</p> <p>All cleaning products are labelled, and the cleaning products are safely stored when not in use. Cleaning and laundry hazards are documented, and material data safety sheet are available. There is adequate personal protective equipment sighted throughout the facility.</p> <p>Satisfaction with cleaning and laundry activities is monitored through surveys and family feedback. Family interviewed state that personal belongings are well looked after by staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>Processes are in place to maintain the safety and security of residents. Working call bells are located throughout the facility with these placed outside most of the bedroom doors. A review of the call bell system is required.</p> <p>The fire service has approved the evacuation scheme and records of biannual fire evacuations are sighted indicating that fire drills are held six monthly. Fire systems and emergency evacuation equipment is checked monthly. A sprinkler system is in place and evacuation procedures are documented. Fire exits are labelled. One fire exit is at the back door of the facility with the opening switch in the hallway further away from the door. There was a false fire alarm in 2017 with the fire alarm activated. The door automatically opened. The New Zealand Fire Service attended, and a report confirmed that all doors opened automatically to enable residents to evacuate the building in a timely manner.</p> <p>Disaster plans are documented for a range of emergencies and outbreak management and pandemic planning is documented in line with the district health board guidelines. Adequate civil defence supplies are available with these stored in a locked area. There is adequate food and water supplied in the event of an emergency. There are supplies and equipment in place in the event of a power outage with an emergency lighting system checked at regular intervals.</p>

		Staff interviewed confirm they receive training in the management of emergencies with training records confirming this. Each shift is covered by a staff member with a current first aid certificate with first aid certificates sighted on staff files reviewed.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility has plenty of natural light throughout. All rooms have at least one good sized window, or external door. The temperature of the facility is maintained at an appropriate temperature for residents. Adequate heating is provided. There are no concerns voiced by family regarding the temperature of the facility. A safe smoking area is provided, away from the building with staff supporting any resident who wishes to smoke.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	PA Low	Shelly Beach Dementia provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The RN is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. 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 and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
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 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 have access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.
Standard 3.3: Policies and procedures Documented policies and	FA	The organisation has documented policies and procedures in place that reflect current best practice. 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 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.		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 is conducted by the ICC and support RN. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
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 infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is 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 minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Shelly Beach Dementia has a commitment to provide quality services for residents in a safe environment and work to minimise the use of restraint. All staff receive education regarding restraint minimisation and management of challenging behaviours. Staff interviewed were clear regarding the difference between a restraint and enabler use. The service currently has no residents using restraint or enablers. A restraint register was 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	Recruitment processes are documented in policy. There are gaps in staff files including confirmation of a signed contract, evidence of reference checking and of criminal vetting.	A review of five staff files indicates that there is missing documentation including signed contracts, evidence of reference checking of new staff and documentation of criminal vetting.	Ensure that each staff member has a signed contract, documentation of reference checks and documentation of criminal vetting. 90 days
Criterion	PA Low	There is a call bell system throughout the facility. The call bells for bedrooms are	Call bells are on the outside walls of bedrooms and may not be able to be accessed by staff, residents (noting that	Ensure that there is a call

<p>1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>		<p>located on the outside of the bedrooms in hallways.</p>	<p>residents may not be likely to ring for help) or visitors when inside the bedroom. Staff state that they do not need to use the call bell system as staff are always present and the home is small enough for others to hear any calls for help. The improvement was identified as being required at the previous provisional audit and the director/manager has been exploring ways of addressing the issue. The risk rating remains as low.</p>	<p>system that a person to call for help if inside a bedroom.</p> <p>180 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	<p>PA Low</p>	<p>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. A documented role description for the ICC including role and responsibilities is in place however an improvement is required in ensuring that infection control programme is reviewed and annual report completed.</p>	<p>The infection control programme has not been reviewed and annual report not completed in the last year.</p>	<p>Ensure infection programme is reviewed and infection control annual report completed every year.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.