

M V and C D Hodson - Westella Homestead

Introduction

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

The audit has been conducted by Q-Audit 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:	M V and C D Hodson
Premises audited:	Westella Homestead
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 15 February 2018 End date: 15 February 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:	26

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Westella Homestead provides residential care for up to 26 residents who require rest home and dementia level care. The rest home is a historic homestead situated in large private grounds. The organisation is a family owned business with the mission of 'supporting people to have a better day'.

There has been a change in management structure since the last audit. There is no longer a facility manager. This role has been divided between the existing general manager (GM) and the newly established role of clinical team leader (CTL).

This surveillance audit was conducted against a subset of the Health and Disability Service Standards and the service's contract with the district health board (DHB). The audit process included the review of policies and procedures, review of residents and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

All previous areas requiring improvement have been addressed. The audit resulted in one area requiring an improvement. This relates to annual staff performance appraisals.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication systems were appropriate to the needs of the residents. Sufficient information is made available. Interpreter services can be accessed if required. Interview with residents and family confirmed open communication opportunities with management and staff.

The complaints process is accessible. Records of complaints sampled confirmed appropriate and timely responses. A register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation is governed by the director who is also the owner. It is a family owned and operated business. The general manager (GM) is employed by this company. The clinical team leader (CTL) is responsible for the clinical day to day running of the home. Organisational performance is monitored.

The quality and risk management system is fully implemented. Quality data is used to improve services. Policies and procedures are current. Adverse events are documented, investigated and closed in a timely manner.

Human resources process ensure suitably qualified staff are on site over the 24-hour period. Competencies are maintained and there are sufficient staff on duty at all times.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents' care plans are developed in a timely manner by the registered nurses. Plans are individualised and comprehensive. Interventions are supported by best practice. Residents' care is evaluated on a regular basis, and more frequently when residents' needs change.

There are well-established processes in place to guide continuity of care. The registered nurses are accessible at all times if assistance is required.

A diversional therapist manages the residents' activity programme, which offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community and can wander freely around the home and gardens.

Medication management is implemented in line with legislation and guidelines. Medication competencies are completed for all staff who administer medication.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance met.

Safe and appropriate environment

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

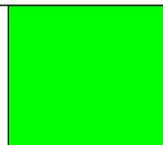


Standards applicable to this service fully attained.

There have been no changes to the facility since the last audit. The building warrant of fitness is current. Trial evacuation are completed as required.

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.

The organisation has processes in place for determining safe and appropriate restraint and enabler use. The grounds are secure, and on the day of audit there were no residents requiring the use of restraints or enablers. There are two rest home residents' who have requested to remain in the facility, despite it being a secure facility are able to independently exit at any time.

Infection prevention and control

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

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	16	0	1	0	0	0
Criteria	0	39	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The clinical team leader (CTL), with the support of the general manager, (GM) is responsible for the management of complaints. A complaints register is maintained. The complaints process is detailed in the service agreement and the information brochure. The complaints sampled confirmed that complaints are dealt with appropriately and closed out in a timely manner.</p> <p>The GM advised that a complaint had been made to the HDC since the previous audit. There has been a decision to take no action in accordance with legislation. The same family took this complaint to the DHB, MOH, and police. Staff report that all investigations undertaken found the complaint to be unsubstantiated.</p> <p>Policies and procedures are compliant with Right 10 of the Code. Quality and staff meeting minutes sampled confirmed staff were involved in the development of corrective actions and outcomes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>The open disclosure policy and procedures set out practice guidelines. Open disclosure to residents and their families occurs within the time frames set in the policy. Clinical records sampled confirmed this occurred.</p> <p>Residents and staff have monthly meetings. Meeting minutes sampled confirmed that information is shared with staff and residents.</p> <p>Interpreter service is available, and documentation provides contact details. In interviews, staff reported that</p>

effective communication.		<p>interpreter services have never been formally required, as staff can provide the service to the one resident that requires help with interpreting. Residents and their families are informed of the interpreter service available in the service agreement.</p> <p>In interviews, residents and family members stated that they feel comfortable discussing any matters with staff or management.</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>CD Hodson is the governing body. The GM and the finance manager report to the owner /director monthly. Reports sampled showed that risks, complaints, quality and trends are covered. The mission, the vision, and the values are included in the business plan. The residents and their families are made aware of the scope of the business in the service agreement. The organisation has a strategic plan which is due for review in 2019. There is a business plan covering 2017-2018.</p> <p>The organisation has restructured the management line and the CTL is now responsible for the day to day management of the facility. The CTL is a registered nurse and has been recently appointed to the position. The CTL position description clearly defines the role. The CTL reports directly to the GM and is supported by the other registered nurse. The GM is responsible for the operations and management of the business.</p> <p>The organisation previously provided both rest home and dementia level care but has been transitioning to dementia care only for some time. On the day of the audit there were 24 residents with dementia and two rest home residents. The two rest home residents have approval to stay from the funders. The organisation also has contracts with the DHB to provide respite and day care 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 ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	Click here to enter text
Standard 1.2.3: Quality And Risk Management Systems	FA	The quality improvement plan guides the quality programme and includes quality goals and objectives. The GM is responsible for ensuring the organisations quality and risk management system is maintained. Quality

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>meetings have been separated out from staff meetings to ensure quality issues are given appropriate attention. Quality improvement data is collected and collated, analysed and reported. Minutes and registers sampled provided evidence that corrective actions are developed, implemented, monitored and signed off. The CTL manages the internal audit programme. The internal audits sampled confirmed that the 2017 audit schedule was completed. Non-conformities were identified and improvements made.</p> <p>Policies and procedures reflect current good practice and legislative requirements and are appropriate for the size and complexity of the organisation. The system is electronic and migrating to a shared platform. Document control processes are in place. This is the responsibility of the GM. Staff interviewed confirmed that policies and procedures provide appropriate guidance for service delivery. The quality plan and risk management plan is relevant to the size and scope of the organisation.</p> <p>The risk management plan identifies risks and sets out management strategies. There is a health and safety system. This includes the comprehensive hazard register, and a process for identifying new hazards.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse, unplanned, and untoward events are documented in the accident and incident register. There are two systems to document and manage adverse events. Residents adverse events are managed through an electronic system referred to as a key performance indicator (KPI) and incidents and accidents are recorded manually. Records of adverse events sampled confirmed that events are well managed, including appropriate immediate actions and the required follow up.</p> <p>The CTL is responsible for managing clinical events and all other events are managed by the GM. Information is collated from both systems and reported on monthly. Quality, staff, and resident meeting minutes sampled confirmed the sharing of information occurs. The GM reports adverse events to the director via monthly reports. Reports sampled confirmed that adverse events are an agenda item.</p> <p>The GM is aware of essential notification reporting requirements. The GM advised that no adverse events have been notified to the DHB since the last audit. Since the last audit there have been improvements in the residents' security system and no dementia resident has left the premises without supervision. Staff confirmed in interviews their awareness of the requirement to report.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>PA Low</p>	<p>The policies and procedures for human resource management are in place. Each position has a documented job description. Professional qualifications are validated. Annual practicing certificates for the registered nurses (RNs) were sighted and all staff have the required dementia level training. The CTL has interRAI assessment training and competencies.</p> <p>The orientation programme includes the induction of all new staff members. Personnel files sampled</p>

<p>practice and meet the requirements of legislation.</p>		<p>confirmed clinical staff received education as per the education plan and that orientation is completed.</p> <p>There is an annual in-service education programme that meets contract requirements. The 2017 programme was sighted with evidence that all planned training was delivered. A plan for 2018 has been developed. This programme covers the essential components for the service and includes education on dementia care and pressure injury. Mandatory competencies include medication administration and first aid. The previously identified area of improvement regarding training has been addressed.</p> <p>An appraisal schedule is in place. An improvement is required to ensure the staff appraisal programme remains current.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a skill mix document that provides the rationale for staffing numbers. The CTL completes the roster. Rosters sampled confirmed the required number of staff per scheduled on each shift. There is a pool of casual staff who are available to cover sick and annual leave.</p> <p>Registered nurse cover is provided daily between the hours of 8.30am to 4.30pm and on an on-call basis at all other times. There is a sufficient number of care givers on each shift with the minimum amount of staff on duty between 11.30pm and 7.30am. This shift is covered by two care givers.</p> <p>Staff interviewed reported there is adequate staff available to provide required care. Family interviewed confirmed staffing levels appear adequate.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medicine management is implemented in line with guidelines and regulations. Medications are administered by registered nurses and care giving staff who have been assessed as competent. Staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management.</p> <p>The organisation uses an electronic medicine management system. Electronic charts include photo identification and allergies. Each medication is individually prescribed. The use of 'as required' medication is monitored. Any as required (PRN) medication administered requires electronic authorisation on the resident's medication chart. PRN medication requests include indications for use. Standing orders are not used. Medications are reviewed by the GP every three months.</p> <p>Medication is securely stored. All medications are dispensed in blister packs. Medication fridge temperatures are monitored. Controlled drugs are stored in a separate locked cupboard. There was one resident requiring regular administration of a controlled drug during the audit. The controlled drug register evidences accurate records.</p>

		<p>There are no residents who self-administer their medications.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for analysis of any medication errors, and compliance with this process is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's 2017 assessment of the menu plan. Food and fluids are available over the 24-hour period.</p> <p>A dietary assessment is undertaken for each resident on admission and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. There is an effective and systematic approach to ensuring that residents' nutrition and fluid intake is monitored and followed up when a concern arises. All residents are weighted monthly.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The previously identified areas required improvement regarding kitchen and cleaning processes have all been addressed. Routine internal audits of kitchen services are being conducted to monitor ongoing compliance. Evidence regarding satisfaction with meals was confirmed during resident and family interviews, satisfaction surveys and resident meeting minutes.</p> <p>The lunch time meal service was observed. There was a sufficient number of staff in the dining room to ensure appropriate assistance was available to residents as needed.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>All care plans include objectives. The interventions required to meet objectives are documented. Interventions sighted were appropriate and based on best practice. Short term care plans have been initiated for short term or acute events. For example, the required observations are documented following a fall and successful wound healing as a result of appropriate dressings and management. Documentation and observations demonstrated that consultation and liaison is occurring with other services as required. Residents and family members expressed satisfaction with the care provided. Implementation of appropriate clinical interventions was confirmed in interview with the GP.</p> <p>The previous areas of improvement regarding interventions to addressed cultural needs, wound</p>

		<p>management plans and updated interventions to manage falls risks have all been addressed.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The diversional therapist (DT) coordinates the residents' activity programme. Activities assessments and activity plans are completed on admission and regularly reviewed. This data is used to develop an activities programme that is meaningful to the residents. Attendance and involvement with activities is monitored. The programme is appropriate for both rest home residents and residents with dementia.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. Residents with dementia have a 24-hour activity plan. Outings take place and residents have signed consents for going on outings. Residents were observed participating in a wide variety of activities during the audit. This included gardening, playing pool, enjoying the garden, 'working', reading, playing games and participating in physical exercises. All residents were observed enjoying the activities they were participating in. The rest home and gardens are large and residents can wander freely and securely.</p> <p>A residents' meeting is held monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The RN's complete routine evaluations of the residents' progress towards identified goals. This is completed every six months, or sooner if required. Goals and nursing objectives are documented in the long-term care plans. Resident care is also evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN's.</p> <p>Where progress differs from that expected, care plans are amended accordingly. A short-term care plan is initiated for short term concerns, such as infections, wound care or changes in mobility. Short term care plans sampled indicated the degree of risk noted during the assessment process. In interview, residents and family confirmed their involvement in the care planning process.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>A current building warrant of fitness is displayed. There have been no structural changes to the building since the last audit. Trial evacuations are completed as required.</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		
<p>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.</p>	<p>FA</p>	<p>The CTL is the infection control nurse. There is a defined infection control programme. The surveillance programme is appropriate to the size and complexity of the organisation. Data on infections is recorded, monitored and measured. Monthly comparisons are maintained. Infection reports are a standing agenda item on the monthly quality and staff meetings. Policy guides reporting requirements in the event of an outbreak. Records sampled confirmed timely and appropriate actions are taken in the event of an infection.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The service demonstrates that the use of restraint is actively minimised. The residents are free to wander round seven and a half acres of gardens. There are no locked doors and residents can enter or leave the building as they like. The perimeter of the grounds are entirely secure with double security gates on entry and exit.</p> <p>There is no evidence of any residents using physical restraints or enablers. Interviews with staff, residents and their family members confirm physical restraint and enablers are not being used in the facility.</p> <p>The two residents assessed as requiring rest home care requested to stay at the facility after rest home level of care changed to dementia level of care. These residents have consented to being cared in secure grounds as they did not want to leave the facility. Review of these residents' files evidenced written consent records, requesting their desire to stay.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There was evidence that staff appraisals were completed annually up until 2016, however there were no staff appraisals completed in the year 2017.	The staff appraisal programme has not been maintained.	Conduct annual staff appraisals as required. 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, 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.