# Glenhays Limited - Southanjer

## 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 The DAA Group 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:** Glenhays Limited

**Premises audited:** Southanjer

**Services audited:** Dementia care

**Dates of audit:** Start date: 13 March 2018 End date: 14 March 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:** 23

# 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

Glenhays Limited - Southanjer provides dementia rest home level care for up to 24 residents. The service is operated by a company of five shareholders and managed by one of two managing directors with the support of a registered nurse. Families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner.

This audit has resulted in a continuous improvement rating in human resources management. There are no areas requiring improvement.

## 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. |

A complaints register is maintained with complaints resolved promptly and effectively.

Residents and family/whānau are provided with information about the Health and Disability Commissioner’s Code of Health and Disability.

Services Consumers’ Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and family/whānau are promoted and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and family/whānau with the information to be able to make informed choices and give consent.

Residents who identify as Māori would have needs meet according to procedures and policies (that have been developed with cultural advisors).

In a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination. The service has links with a range of specialist health providers to support best practice and meet residents needs.

## Organisational management

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

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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. |

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents and special needs are catered for. Food storage is appropriate and food is safely handled. Meals are of a high standard and residents weights are maintained.

## 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. |

The facility is clean and tidy and meets the needs of the residents. The building warrant of fitness is current. Electrical testing and tagging is performed on all equipment. Heating throughout the building is maintained at a comfortable temperature. External areas are accessible and offer comfortable seating.

Waste and hazardous substances are collected weekly or sooner if required. Staff use personal protective equipment which is readily available. Chemicals are stored in accordance with legislation, and safety data sheets are prominently displayed.

Emergency equipment, supplies and procedures are readily available, and staff are familiar with procedures and attend regular fire evacuations practices. Call bells are in each room and were seen to be answered in a timely manner. There have been no security breaches.

## 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. |

Southanjer has policies and procedures that support minimisation of restraint. At the time of the audit there were no restraints in use. An assessment, approval and monitoring process with regular reviews occurs, should restraint be required. Staff have a good understanding of the restraint process and are aware that it is only used as a last resort.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| 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 infection prevention and control programme, led by an experienced registered nurse aims to prevent and minimise infections. The programme is reviewed annually. Specialist advice is available to be sourced through the local district health board if required.

Staff had a good understanding of the principles around infection control and were familiar with the policies and procedures. Annual training is provided by suitably qualified staff. Surveillance appropriate to aged care is undertaken and reported to the general management committee with follow up as and when required.

## 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 93 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 | Southanjer has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed had an understanding of the Code and were observed to approach residents’ rooms and knock before entering. Staff have received education on residents’ rights, advocacy, independence and individuality, privacy and dignity on the 22 January 2018; attendance record were sighted. |
| 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 | Signed informed consents were seen in each clinical file. The interview with the RN confirmed that a discussion was held with family/whānau during the admission process. Advance care plans were not available. EPOA was activated for each resident prior to admission and sighted in file.  Staff were seen to be asking for permission for day to day care. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | At admission, family/whānau are given copies of the Code and Advocacy Services brochures. This information is also displayed in the foyer along with contact details but has not been accessed in recent times. Staff received training on the Code and advocacy in January 2017 (attendance records sighted). |
| 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 | Family/whānau are very involved in taking residents out and being included in inhouse activities. The activities programme also run outings in the van to local places of interest. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to families on admission and those interviewed knew how to do so.  The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The poster of the Code was on display in the foyer along with brochures. As part of the admissions process, Enduring Power of Attorneys (EPOAs) were given a copy of the Code and discussed it with the manager. EPOAs are involved with all residents at this stage as all residents have had them activated prior to admission due to decline in cognitive function, sighted in resident files as activated. |
| 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 | Families confirmed that residents received services in a respectful manner, that took into account their cultural beliefs, privacy and personal choices. Each resident has their own room decorated with familiar possessions, and doors were shut to maintain privacy. Progress notes were appropriately written and kept in the locked nurses station.  Care plans are written to include current abilities and ways these can be maintained, with regular evaluations. Care plans also documented cultural, social and spiritual needs.  Staff have had ongoing education on de-escalating techniques and are encouraged to remove themselves from challenging situations, while also ensuring resident safety. There has been no evidence of situations of abuse and/or neglect. Staff receive annual training on abuse and neglect; this is next due in August 2018. |
| 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 | At the time of audit there were no residents who identified as Māori. There are policies and procedures that show a Māori health plan has been developed with the assistance of cultural advisors. Staff interviewed confirmed they are aware of the Māori health plan and the importance of family/whānau. |
| 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 | Residents’ files showed that family/whānau were involved in planning their care with personal preferences and special interventions documented. A recent family satisfaction survey confirmed this occurred and that individual needs were being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The family satisfaction survey showed that residents were free from harassment and any type of exploitation, which was reiterated by staff. On observation the residents appeared happy and actively involved in the life of the facility.  Staff had completed required training on professional boundaries and expected behaviour at induction. A senior caregiver is running a mentoring programme for new staff to discuss and improve on behaviour and empathy in resident interactions. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages best practice by having staff attend external courses, such as ‘Walking in Another’s Shoes’, and through the mentoring programme.  Allied health professionals are available to be contacted to ensure a high standard of care. The general practitioner (GP) confirmed that medical treatment is sought in a timely manner.  Staff indicated that they receive support from management to attend external training and that online training is also being utilised. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents’ family/whānau were updated with any changes and included in discussions for future planning of care, as confirmed by the progress notes. An open-door policy is in place at Southanjer. Online training was held in December 2017 on communication.  Contact details for interpreters were available through the local district health board. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The business plan which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The document describes annual and longer term objectives and the associated operational plans. A sample of quarterly reports to the shareholders showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, occupancy and staffing.  The service is managed by one of the company’s managing directors (manager) who holds relevant qualifications and has been in the role for less than one year. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing training, attending conferences and residential care sector meetings.  The service holds contracts with the DHB for residential dementia care and respite care. Twenty-three residents were receiving services under the contract at the time of audit. There were no respite residents. |
| 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 manager divides her time equally between two sites on a daily basis, and is on call at Southanjer because she lives on site. A registered nurse (RN) with over 10 years experience at Southanjer provides clinical oversight and works up to 20 hours per week.  When the manager is absent, the registered nurse carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a second registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. |
| 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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and medication errors.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the general committee meeting, risk assessment and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and participation in quality meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed family stated that rooms look ‘tired’. The manager reported that the shareholders have since engaged a consultant from an interior design firm to provide guidance on refurbishing rooms.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. |
| 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 | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the general committee and shareholders three monthly meeting.  The manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of significant events made to the Ministry of Health, since the previous audit, this was included and sighted on a Section 31 form. |
| 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 | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.  Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member is the internal assessor for the programme. Staff have either completed or are enrolled in the required dementia care education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.  Continuous improvement in relation to staff culture and team work was evident. |
| 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 a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Family members interviewed supported this.  Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. An additional staff member has been rostered on the night shift three times a week to provide cover for the manager who lives on site. At least one staff member on duty has a current first aid certificate. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 | Residents enter the service when their required level of care has been assessed and specialist referral to the service is confirmed by the local Needs Assessment and Service Coordination (NASC) team. Prospective residents’ families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC and the GP for residents accessing respite care. An enduring power of attorney (EPOA) has consented for the resident to be admitted.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort if family cannot attend. The service uses a documented transfer system to facilitate transfer of residents to and from acute care services. There is open communication between all services and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed family were kept fully informed throughout. Family of the resident reported being kept well informed during the transfer of their relative. |
| 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 | The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.  Controlled drugs are able to be stored securely in accordance with requirements and checked by two staff for accuracy when administering. There are no controlled drugs being administered at the time of audit.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and complied with guidelines.  There were no residents who self-administer medications at this dementia facility.  There is an implemented process for comprehensive analysis of any medication errors. |
| 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 | Family/whānau are included in formulating a nutritional file that includes likes/dislikes/specific dietary requirements and religious/ethnic preferences. The menu consists of a four-week rotating summer/winter menu. The menu was signed off by a qualified dietitian as nutritionally appropriate for aged care in February 2017. The food is sourced from local suppliers and cooked by a qualified chef. Pantry staples are stored neatly and evidence of rotation was observed. All stock was dated in line with current requirements. Waste disposal was appropriate. The kitchen was clean and tidy and evidence of temperature checking of fridges/freezers and hot foods were apparent.  Snacks are available for anytime a resident is hungry.  A resident who required assistance received her meal in a discreet, unhurried manner. All residents’ files seen showed stable weights. |
| 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 | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and continence assessment, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of two trained interRAI assessors. Families confirmed their involvement in the assessment process, and they observe service provision according to their input and information. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed, and particularly in relation to the dementia specific care required. Behaviour management plans are in place for triggers and interventions for behaviour management.  Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans, and staff listened and implemented interventions after discussion with them. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision and was confirmed by families. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very good standard. Staff confirmed that care was provided as outlined in the care plan and this was observed during the audit. A range of equipment and resources was available, suited to the level of care provided, dementia specific and in accordance with the residents’ needs. |
| 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 | The activities programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy, two caregivers who are employed as activities staff for four shifts a week, and a rostered volunteer.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated monthly and as part of the formal six-monthly care plan review. All staff, including the chef, are involved in ensuring there is a social vibe at Southanjer.  Activities for residents from this secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active or restless. Families are involved in evaluating and improving the programme through family meetings and satisfaction surveys. Families interviewed confirmed they find the programme varied and appropriate. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN or manager.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and behaviour. When necessary, and for unresolved problems, long term care plans are added to an updated. Families interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| 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 | Residents are supported to access referral to other health and disability service providers. Families may choose to use the medical practitioner of their choice for residents. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the mental health team. The family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Policies and procedures are followed for the management of waste disposal. A local firm removes waste weekly or sooner if required. Sharps are collected when full and are stored in a locked cupboard. Appropriate signage was in place. Chemicals are stored in a locked cupboard. Material safety data sheets were evidenced wherever chemicals are used (eg, laundry and kitchen). Spill kits are available. Personal protective equipment was available and seen to be used. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building warrant of fitness was current and displayed in the foyer. There have been no changes to the configuration of the buildings since the previous audit.  Testing and tagging of electrical equipment and calibration of medical equipment occurred on 11 September 2017. Water temperature checks are carried out monthly and a plan is in place to call a plumber if the temperature is still not in normal range within two days. Corridors were clear of clutter. Staff interviewed knew where to write required repairs and the maintenance book showed prompt action taken. Family members confirmed that corridors are free of clutter.  There is a safe walkway in an enclosed courtyard where residents are able to participate in purposeful walking. |
| 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 | Bathrooms and showers are scattered throughout the building and are sufficient for the number of residents. Non-slip surfaces are supplied for showers. Appropriate stools and rails are in place where required. |
| 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 | Residents all have single rooms of large size, which they are able to move around in safely. Rooms are personalised with furnishings, photos and personal affects. There is storage available for walking frames. |
| 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 | Communal rooms were adequate for the number of residents and activities being held within a conservatory that could be used for private family gatherings. Furniture was suitable for comfort and practicality.  The dining room had adequate space for staff to move freely between tables. |
| 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 | There are two laundries on site, one for personal belongings and one for linen. Both had clean/dirty flow and were kept tidy. Linen trolleys were covered and appropriate personal protective gear was worn. Due to the size of the facility, specific laundry staff are not employed but rather a caregiver is assigned to the laundry once personal cares were completed. The same process applies for cleaning. On the day of audit, the building was clean and uncluttered. Residents were dressed in clean tidy clothes. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The manager reported appropriate planning, policies, and procedures are in place if a civil emergency occurred. Emergency kits, bulk water, nursing supplies, batteries, and torches were all observed, along with checklist and dates for replacing water regularly. Staff interviewed were aware of this equipment/supplies and all staff are first aid trained. In recent power outage the manager stated that the emergency lighting functioned for ‘over an hour’.  The building is locked, windows secured and curtains pulled in the evening. The manager lives on site and there is always someone on call.  Fire safety training is held regularly both formally and through ‘manager initiated’ practices. Last evacuation was held 30 January 2018. Further education is due in July 2018. Staff interviewed were familiar with the process of evacuation and emergency procedures.  Call bells are available in all rooms and from observation were answered promptly. |
| 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 | Bedrooms and communal areas are heated and ventilated to an appropriate temperature. Natural light is well utilised, with skylights in the corridors and all rooms have a large window with views of surrounding countryside. Staff confirmed during interview that the building was warm. |
| 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 RN is the designated IPC whose role is described in the job description and reports to the manager as required, and at the monthly staff meeting. An infection prevention and control programme is in place to minimise risk of infection to residents, staff and visitors. The programme is guided by a comprehensive infection control manual. Both manual and programme are reviewed annually.  There is a sign at the entrance encouraging unwell visitors to remain away, and staff are also encouraged to remain at home if unwell. Staff confirmed they are aware not to come to work when sick.  Infections and surveillance data are gathered monthly, analysed for trends and presented at quality meetings and feedback is given to staff at staff meetings. |
| 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 RN holds the role of infection prevention coordinator. The position is supported by a robust infection control programme and the support of management. Local DHB and medical laboratories are available for advice. Hand washing and outbreak management education was held in November 2017 with good attendance. |
| 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 | Documented policies and procedures for the prevention and control of infection reflect good practice and relevant legislative requirements. For instance, Alcogel hand wash is available throughout the facility. Personal protective equipment is readily available and staff were observed using it. Policies are reviewed annually, last in February 2018.  Education is ongoing and reflects the surveillance information. For example, if a high incidence of urinary infections is observed then an extra hand washing training will be given and staff will assist residents in hand washing. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews and attendance records showed that staff receive education in infection prevention and control at induction and on an ongoing basis. The RN takes the education sessions with input from external sources and some online training.  Staff support the residents with such things as handwashing. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities. It includes infections of the urinary tract, respiratory tract, skin, and eye as well as fungal infections. Each resident has a list of their acquired infections showing, onset, treatment, and outcome in their file. The infection prevention and control coordinator/RN records each month’s infections on an infection report form, collates the data, creates graphs for comparison month to month and with previous years to observe for trends and possible causative effects. These results are reported to quality and risk management meetings, and feedback is given to staff at monthly meetings. Additional staff training can occur as a result of findings. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Currently there are no restraints or enablers being used. No restraints have been used in the last year.  Policies and procedures are in place that meet the restraint minimisation and safe standards guidelines. Southanjer is committed to promoting a restraint free environment and education is based on alternatives, and de-escalation techniques. Staff are aware restraints are only used as a last resort. Training in July 2018 is planned and will focus on de-escalation and challenging behaviours.  The manager is the restraint coordinator and had a good understanding of the policy. An approval group meets annually to review the training and policies. Restraint management meeting minutes were sighted, and feedback given at staff meetings. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | CI | A poor culture and lack of team work was identified at Southanjer by the new management team. A family survey on staff culture gave feedback that politeness and courteousness can fluctuate depending on who is on (eg, ‘some staff can appear sullen when visiting – attitudes could be better’).  As a result of the family survey, and staff feedback the manager implemented a project to improve team work and staff culture and create an overall atmosphere that the residents and family were able to enjoy and feel at home. The manager engaged an external consultant for staff training in culture and attendance by all staff was compulsory. The study day was aimed to ‘develop a sustainable culture of excellence in everything that you do’. Feedback from staff showed that it was enjoyed and relevant to all attendees. Four staff enrolled in and are completing Walking in Another Shoes’ programme.  A staff mentoring programme has been developed for all new staff and any others that wish to participate. Discussions in this forum focus on different skills that can be used to ensure that Southanjer is as homely and welcoming for residents as is possible. A senior caregiver is involved in the recruitment process. She is part of the panel to assess if potential applicants would fit in the team.  An evaluation has occurred that demonstrated improved outcomes for residents. Families have provided written feedback and report that: ‘The culture of the team is excellent, and this is reflected in the environment that has been enhanced for the residents’; ‘The team culture at Southanjer is excellent’; ‘We cannot speak highly enough of the culture of Southanjer’; ‘A complete staff turnaround in staff attitudes, a warm open and caring place’. | Continuous improvement in relation to staff culture and team work was evident. A specific quality improvement project was implemented to improve team work and staff culture and create an overall atmosphere that the residents, and family, were able to enjoy and feel at home. The evaluation and reviews of the strategies introduced to date have shown a change in culture and improved resident outcomes. |

End of the report.