# The Grail Movement Foundation of New Zealand Limited - Komatua Care Centre

## 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 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](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:** The Grail Movement Foundation of New Zealand Incorporated

**Premises audited:** Komatua Care Centre

**Services audited:** Dementia care

**Dates of audit:** Start date: 11 April 2018 End date: 11 April 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:** 12

# 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

Komatua Care Centre is a 13-bed aged care service that provides specialist secure dementia level care. At the time of audit there were 12 residents. There have been no changes to the organisation since the last audit.

This certification audit was conducted against the relevant Health and Disability Service Standards and the organisations contract with the district health board. The audit process included a document review, review of resident and staff files, observations and interviews with family, management, staff and the general practitioner.

A continuous improvement rating has been allocated as a result of a quality initiative and one area requiring improvement was identified.

## 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. |

Documented procedures, interviews with residents, family members and staff, together with observation confirmed that residents’ rights are understood and met in everyday practice. Communication channels are clearly defined and interviews and observation confirmed communication is effective. Information on rights and services is provided in an appropriate manner.

Residents are free from discrimination and have access to advocacy services. Reports or allegations regarding concerns are followed up and remedied in a timely and appropriate manner. The manager lives on site and has an open-door policy.

Informed consent requirements are clearly defined. Links with community resources are supported and facilitated. Visitors are free to come and go.

The complaints process complies with legislation. A complaints register is maintained. Complaints are used as an opportunity to improve services.

## 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. |

The organisation is privately owned. There are three trustees. The purpose, values, scope, direction and goals of the organisation are reviewed and monitored.

The organisation has a quality and risk management system in place that is monitored and reviewed to generate improvements in practice and service delivery. The required policies and procedures are in place and accessible. Key quality goals are defined and achievement towards these goals are reported and communicated during regular meetings. The organisation implements an internal monitoring programme. Corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The adverse event reporting system is well managed.

Human resource management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hours with experienced advice and assistance available. There is an in-service education programme.

Resident information is securely maintained, integrated, current and up to date.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

A process for entry into services is managed by the manager as per identified level of care. The registered nurse and the medical practitioners are involved in the admission process.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach. Care plans are developed by the registered nurse and assessments are completed and evaluated in a timely manner. Families reported that they are satisfied with the care planning process.

Planned activities are meaningful and appropriate to the residents’ needs and setting of the service. The diversional therapist is responsible for coordinating the activities program. Preferences of residents, are sought and incorporated in the planned activities.

The medication management system meets the required legislation and guidelines. Medication is administered by competent staff. An electronic system in prescribing, dispensing and administration is in use.

Food services are provided at the facility. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.

## 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 homely and appropriate to the needs of the residents. All equipment is in good working order. There are well-furnished lounge, dining and external areas are accessible to all residents. The facility is secure and has secure outdoor areas. There is plenty of natural light and the facility is maintained at a comfortable temperature. Bedroom areas are sufficient in size to allow for personal possessions. Toilet, shower and bathing facilities are sufficiently equipped and well maintained. Applicable building and fire regulations are met.

Cleaning and laundry services meet infection control requirements and are of a good standard. Collection, storage and disposal of waste is in accord with infection control principles and council requirements.

Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic.

## 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 service maintains a process for restraint approval and authorisation and the policies and procedures state that restraint minimisation and safe practice is the goal. There were no restraints or enablers in use on the day of the audit. The facility is secure with locked entry and exit.

## 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. |

Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. The infection control coordinator is responsible for coordinating education and training of staff. The infection control programme is reviewed annually.

Infection data is collated monthly, analysed and reported. The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported in a timely manner.

## 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 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 1 | 90 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Policies reflect the Code of Health and Disability Services Consumer Rights (the Code). The Code is included in the orientation of all new staff and staff interviewed demonstrated knowledge of the Code. The Code is also discussed as part of the annual in-service education programme. Residents and relatives interviewed, and observation during the audit, indicated that staff understand resident rights and their responsibilities and that resident rights are observed in practice. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Policies and procedures on consent support the residents’ right to make informed decisions. The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives.The residents' files sampled had the required consent forms signed by the enduring power of attorney (EPOA). Staff acknowledged the resident's right to make choices based on information presented to them. Residents and family members interviewed confirmed that they were provided with day to day choices and consent was obtained. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff receive training on the right to advocacy / support. Family interviewed confirmed they are provided with opportunities to support their family members at any time of their choice. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | There are no set visiting hours and relatives are encouraged to visit at any time. Family reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. Evidence of community access was sighted in resident records sampled. |
| 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 procedure are in line with Right 10 of the Code. Residents and family interviewed confirmed access to the complaints procedure. The complaint forms are readily available, as are the contact details for advocacy services. Staff receive education on the complaints process during orientation. A complaints register is available. This includes the nature of the complaint, actions and outcomes. Implementation of the current complaints process could not be verified as there have been no complaints since the last certification audit, however discussions with the manager confirmed an understanding of the required process.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Information about the Code, advocacy services and the complaints process is provided on admission and displayed for easy access. Residents and families interviewed are aware of their rights and family confirmed that information was provided to them during the admission process. Residents’ agreements are signed by the enacted enduring power of attorney (EPOA). Resident agreements meet the requirements of this standard and district health board (DHB) requirements. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The privacy and dignity policy details how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents’ related information. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting resident’s individual beliefs and values. Personal property is maintained in a secure manner. Policies and procedures on abuse and neglect include definitions and reporting requirements. Observations made during the audit confirmed that staff were respectful of personal privacy during the delivery of care and when entering residents’ rooms. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The Maori Health Plan includes Maori models of health and barriers to access. Cultural needs are included in the care plans (if identified). There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. Cultural safety training is provided to all staff. There were no residents who identified as Maori at the time of the audit.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Cultural needs are identified on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in as recognised by the resident and family. Values and beliefs are discussed and incorporated into the care plans. Family members interviewed confirmed that they are able to be involved in the development of the long-term care plan and are given the opportunity to discuss the needs of their family member.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies define processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct and professional behaviour are included in the employment and orientation process. Staff receive information and education regarding non-discriminatory attitudes and behaviours. Interviews with residents and family, and observation during the audit, indicated that residents are free of any form of coercion or discrimination. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Good practice is maintained, encouraged and monitored. Staff reported that they are satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence-based practice. There are regular visits by the GP and allied health providers as required. An experience registered nurse is on site three days per week and available on call as required. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Staff training includes appropriate communication methods. The service has required access to interpreting services if this was required. Policies and procedures are in place if the interpreter services are needed to be accessed. Documenting of open disclosure following incidents/accidents was evident. Families reported they are informed of any events or concerns. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation has three trustees, one of which is the owner/manager and one whom also works on site as an enrolled nurse. The owner/manager is responsible for day to day operations. The owner/ manager has been in the role for over 30 years and regularly attends education relevant to dementia care, care of the older person and management. Education records were sampled.The mission, values and goals are documented. There is evidence that the business plan is reviewed and updated annually. Goals for the coming year are set and monitored. The rest home provides care to residents who have been assessed as requiring dementia level care. There were 12 residents on the day of the audit – nine with aged related care contracts and three with long term care contracts, (two under the age of 65 years). |
| 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 | In the event of absence of the owner/manager, the other trustee is given the delegated authority to fulfil the role. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is a documented and implemented quality and risk management system. The owner/manager is responsible for ensuring that all quality and risk management activities are implemented with clinical oversight from the registered nurse. The required policies and procedures are documented. These are developed by an external consultant. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff and staff orientation includes an introduction to the system. All documents sampled were current and controlled.Quality goals are developed annually. Achievement towards quality goals is documented. Quality activities and quality data are discussed and monitored through monthly staff meetings. This includes complaints (if there have been any), review of incidents and accidents, health and safety and the results of internal audits. Audit action forms are maintained which include all the corrective actions from the previous month. There is an annual review of all aspects of the quality and risk management programme including infection control. The organisation has been proactive in implementing quality initiatives. This has resulted in a continuous improvement rating. Family are kept informed through regular newsletters. There is an annual family satisfaction survey with family indicating that they are satisfied or very satisfied with all aspects of care. This was confirmed in interviews with all family members. The organisation has a risk management programme in place. Organisational risks are documented in the business plan. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of the hazard register being updated as new hazards are identified. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | There is evidence that adverse events are reported as required. In interview, the owner/manager understood their obligations in relation to essential notification reporting. Incident and accident management is included in staff orientation.A number of incidents were sampled. These provided sufficient evidence that adverse events are linked to the quality system and used as opportunities to improve services. Emergency management and remedial actions were appropriate and timely. The majority of incidents are related to behaviours of concern or falls. There is evidence that families are notified of any adverse events. This was confirmed in interviews with family members. |
| 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 | The registered nurse (RN) has a current annual practicing certificate (APC). Current practising certificates were also sighted for other health professionals who work with the organisation, for example the general practitioner (GP), enrolled nurse (EN) and pharmacists. All health care assistants have achieved, or are working towards, the required dementia training. All staff have a current first aid certificate and a food safety certificate was sighted for the cook.All staff receive an orientation on commencement of employment. Orientation checklists were sighted in all staff records sampled. The orientation includes the essential components of service delivery. On-going education is provided. The education programme includes aspects of aged care and dementia. This includes relevant education provided by the DHB gerontology nurse specialist. The RN has completed interRAI training. The required competencies are maintained and monitored, for example medication competencies. In addition, articles of interest are presented at staff meetings, and signed off as read by staff. Staff performance is monitored. The required annual appraisals and skills assessments were sighted in staff files sampled. |
| 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 policy on staffing levels and skill mix. There is a minimum of two staff members on the roster for each day shift, and one at night. In addition, the owner/manager and one staff member live on site and provide support as required and are on call after hours. The registered nurse is on site three days per week and the cook is onsite Monday to Saturday. Rosters sampled confirmed sufficient staffing over the 24/7 period. The owner/manager reports that additional staff are called in when required, for example during busy periods, sick leave or annual leave. This was confirmed in both family and staff interviews. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Residents' demographic information is documented on entry. The admission assessment includes verification and documentation of individual resident information. The sample of residents’ records indicates that they include reports from all health professionals. Records are integrated in the one file. Entries are legible, dated, signed and designated. Resident records are written by staff at the end of each shift. These are reviewed weekly by the RN.All resident records are secure and private. Records are stored away from the service delivery area. Archived records are securely stored onsite and maintained for 10 years.  |
| 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 service’s entry criteria is clearly documented and communicated to the consumer’s, their family/whanau representative, local communities and referral agencies in the facility brochure. Entry screening processes and assessment processes are clearly stated. The information is adequate and accurate about the services provided and is made available to consumers preadmission. |
| 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 planned exit, discharge or transfer process in collaboration with the resident when possible and this is communicated with the family/whanau or representative of choice. Yellow envelopes are utilised to transfer between the facility and the local DHB. Required information is documented on the DHB transfer form to minimise risks associated with each resident’s transition, exit, discharge or transfer. |
| 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. | PA Low | A medicine management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, and storage and medicine reconciliation. An electronic medication management system is in place. Pre-packaged medications are in use. Three monthly medication reviews are completed by the GPs’. Electronic records were sighted. Medication is stored safely in a locked cupboard. There were no controlled drugs onsite on the day of the audit. Medication administration competent healthcare assistants and the registered nurse administer medications. Medication administration competencies were all up to date. On the day of the audit one medication round was observed. Procedure completed as per medication administration guidelines. Medication reconciliation is completed by the registered nurse. An improvement is required regarding the disposal of expired pro rata (PRN) medication. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Meals are prepared at the facility and served in the dining room or delivered to the resident’s room if preferred. Residents’ dietary profiles are completed on admission and food preferences and allergies are documented and communicated to the cook. Special diets are catered for per rising need. Food and fluid is available for residents 24 hourly. Interviewed family reported satisfaction with the food provided.On the day of the audit the kitchen was observed to be clean, the pantry well packed and no food packages stored on the floor. The cleaning schedule was sighted as well as food temperature monitoring records. There is an ordering/procurement system in place managed by the manager and the cook. A first in first out system is in place for the use of stocks. Cooked food was dated, covered and labelled. All food handling processes comply with the current legislation and guidelinesThe cook has food handling training and certificates were sighted. Appropriate use of protective equipment as per nutritional guidelines was sighted. |
| 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 | To ensure safety of the consumer, a process for managing declined referrals/entry to services is in place. Documentation is maintained and consumers or their family of choice are advised of the reason for this and are informed of other alternative services available. Evidence of referral to other health and disability services was sighted in the sampled files. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The service uses their own nursing assessment tools and interRAI assessments to identify the residents’ needs, goals and desired outcomes. The registered nurse is responsible for completing interRAI assessments and care plans with the input from the residents’ families or chosen representatives, the GPs’, referrers, other nursing staff and other relevant service providers. Assessment records were sighted and they serve as a basis for service delivery planning. Identified resident’s needs are addressed in the residents’ care plans. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans were individualised, interventions to achieve the desired outcomes were detailed and up to date in the sampled files. Service integration is demonstrated in the care planning process. There was evidence of residents’ and family/whanau of choice/representative involvement in the care planning process. Interviewed family reported that they are happy with the care planning process. Care plans demonstrate multidisciplinary team involvement in the care planning process. Specific care plans are implemented for acute cases to address identified short term residents’ needs. |
| 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 interventions are adequate to meet the residents’ assessed needs and desired outcomes. The interventions are evaluated and updated in a timely manner. Specialist services are engaged in the support of the residents when required. The required and appropriate interventions were sighted in resident files sampled.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are individualised activities plans for each resident. Activities history and interests is gathered on admission and the diversional therapist is responsible for activities assessments and activities care planning. A 24-hour activities plan is completed for each resident and documentation was sighted in the files sampled. The activity plans take into consideration residents’ strength, abilities and interests. The activities plans are evaluated six monthly or as required. There is a wide range of activities offered including community events, art, one on one walks and music therapy. A continuous improvement rating has been allocated to the music therapy initiative (refer to criterion 1.2.3.6). Interviewed family members expressed satisfaction with the activities program. On the day of the audit, residents were sighted participating in different activities of interest. The activities program is posted on the notice board. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | InterRAI assessments and care plans are evaluated six-monthly and more frequently when there is a change in the residents’ condition. Sighted evaluation records are resident focused and indicated degree of response to the interventions progress towards meeting the desired outcomes. Where the desired outcome is not achieved, changes are made to interventions and the care plan updated. Specific care plans are evaluated and closed off 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 | Residents’ family/whanau or representative of choice are advised of options to access other health and disability services where indicated or requested. Records of family involvement in accessing specialised therapy services were sighted. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented policies and procedures for the management waste and hazardous substances. Personal protective equipment is available throughout the facility. Domestic waste disposal meets council requirements and is removed from site as required. Infection control policies include the use of single use items. Chemicals and used products are securely stored or disposed of. Hazardous substances, for example oxygen cylinders are safely stored. All staff receive training on the use of personal protective equipment (PPE) and the management of waste and hazardous substances. Staff were observed using PPE correctly during the audit. |
| 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 facility is set in a suburban street and although it is a secure dementia facility there is nothing to distinguish it from the other villas in the street. The entrance gate is high enough to provide a secure setting. There are safe external areas for the residents to use. There have been no changes to the facility since the last certification audit, with the exception of minor refurbishments and upgrading.There is a current building warrant of fitness. Electrical testing is conducted. Medical equipment is calibrated. Furniture is provided and well maintained. Routine maintenance is completed as required. The entire facility is well kept and provides a homely environment suitable to the needs and demographics of the residents. There is a documented and implemented health and safety programme. All hazards are identified.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are sufficient numbers of toilets, showers and bathing facilities. All rooms have a hand basin and some a toilet. Hot water is maintained at a consistent temperature which is checked regularly. Records of temperatures are maintained and any variations are reported to management. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities, including maintaining privacy. |
| 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 | There is one double room. All others are single occupancy. Family consent for sharing the double rooms was sighted in resident records sampled. The bedrooms are of sufficient size and well decorated, including personal property.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | All areas have adequate and well-furnished lounge and dining areas. These areas are well utilised and sufficiently sized. Private rooms can be used as low stimulus areas if required. Residents and family members interviewed voiced no concerns regarding the communal and dining areas. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry services meet infection control requirements and are of an appropriate standard. All laundry is washed on site. Day to day cleaning is completed by the health care assistants. Staff are trained at orientation in the use of equipment and chemicals. Documented guidelines are available and duty schedules for cleaning and laundry are provided for both day and night duties. Material data safety sheet are displayed. Cleaning and laundry hazards are documented.There have been no concerns raised regarding cleaning and laundry services. The effectiveness of the cleaning and laundry service is monitored by the owner/manager and included in internal audits.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The fire service has approved the current evacuation plan records of biannual fire drills are sighted. Evacuation procedures are displayed. Emergency management training is included in staff orientation.There are sufficient emergency supplies in the event of a civil defence emergency or pandemic planning. This includes is supplies of food, equipment and water. The building has emergency lighting in the event of a power failure and BBQ facilities.There are no call bells in resident rooms, however a system is in place so that staff can summons help at any time. This includes a pendant carried by each staff member at all times. Security is maintained. The entrance is secured with locked gates.  |
| 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. All rooms have at least one good sized window for natural light. There is plenty of natural ventilation and sunlight. Interview with residents and family indicate that the internal environment is maintained at a comfortable temperature. There are three residents who smoke in a designated smoking area outside and away from other resident areas. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The RN is the infection prevention and control coordinator and reports directly to the owner/manager regarding infection control issues. The role of the infection prevention and control coordinator is defined. There is evidence that the infection control programme is reviewed annually. The review includes an annual analysis of all infections over the last 12-month period. Records of the 2017 review demonstrated that improvements were made to the programme as suggested by the medical practitioner regarding the management of cross infection. Handwashing information is available and displayed. All residents and staff are offered annual flu injections. Residents’ consent to receiving a flu injection is signed by their EPOA. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | All staff are responsible for implementing the infection control programme and related activities. Infection control matter are discussed during staff meetings. There is evidence of additional advice and expertise from the medical practitioners when required. The RN has completed additional training on infection prevention and control. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The required infection prevention and control policies and procedures are documented and reflect current best practice. Staff demonstrated knowledge on the requirements of standard precautions and are able to locate relevant policies and procedures. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | All staff receive education regarding infection prevention and control. This is provided during orientation and ongoing online training. Training and attendance records are maintained. The RN has recently attended a DHB training on recognising infection and sepsis.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The 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 trends or common possible causative factors. All results of surveillance and specific recommendations are to assist in achieving infection reduction and prevention outcomes. These are acted upon, evaluated and reported to staff. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service maintains processes for restraint use minimisation and safe practice. Restraint policies and procedures are in place and serve as a guide for staff. The restraint approval process, assessment and evaluation is managed by the manager in consultation with the registered nurse, family and GP. The manager is the restraint coordinator and a job description for the restraint coordinator was sighted. Restraint education training records for all staff was sighted. Interviewed staff demonstrated knowledge of the difference between an enabler and restraint and are aware of alternative methods that can be used to minimise restraint use. Staff restraint competencies are current and up to date. No individual restraints or enablers were in use at the time of the audit. There is environmental restraint in place in the form of a coded gate and main entrance door for residents’ safety. Families and visitors have access to the code when required. |

# 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 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | During the audit it was noted that there was expired PRN medication in the storage cupboard. This was rectified on the day of the audit. | The process for medication disposal did not consistently meet the medication guidelines. | Ensure expired PRN medication is returned to the pharmacy consistently as per medication guidelines.90 days |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The organisation researched international strategies for best practice when working with people with dementia and chose to implement a memory through music programme called Alive Inside. Four residents were chosen for a trial of the programme. Families were notified in writing and asked to develop play lists for their family member. The programme required the resident to have two 20-minute sessions per day listening to music through ear phones. A measuring system was used to determine the residents’ response to the music. All residents involved in the trial had a MoCA (Montreal Cognitive Assessment) completed a prior to the trial and ongoing during the trial. Outcomes were measured based on speech/communication, engagement, depression/anxiety and a description of the resident pre-music therapy. This programme was led by the diversional therapist and resulted in marked improvements for the residents involved. One resident who was previously non-verbal is now communicating verbally and one family member reported a marked improvement in both behaviour and communication with their family member. The organisation now intends to implement the programme for all residents.  | The organisation exceeds the requirements of this standard. A quality initiative has resulted in improvement outcomes for residents. The research-based initiative provided both qualitative and quantitative data. Outcomes were monitored and analysed.  |

End of the report.