

# Deakoda Holdings Limited - Shalom Aged Care

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** Deakoda Holdings Limited

**Premises audited:** Shalom Aged Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 14 May 2018 End date: 15 May 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:** 30

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Shalom Aged Care is certified to provide rest home level of care across 30 beds. On the day of the audit there were 30 residents living at the facility and all were under the aged residential care contract.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

Shalom Aged Care is privately owned. The owner is on-site two days a week and assists with maintenance. Day-to-day operations are delegated to two experienced managers. The administration manager has been at the facility for nine years. The second manager is a registered nurse with a current practicing certificate who has over 30 years of aged care experience. Both managers have maintained over eight hours annually of professional development activities related to managing an aged care facility.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services.

The one shortfall identified as part of the previous audit has been addressed. This was around reporting to staff meetings.

This audit has identified further improvements required around; staff appraisals, first aid certificates and timeframes.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a business plan with goals for the service that has been regularly reviewed. The service has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The staffing policy aligns with contractual requirements.

## 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.
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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident. Family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activities coordinator. All meals are prepared on-site. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

## 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.
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There is a current building warrant of fitness.

## 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.
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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

## 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## 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)
<b>Standards</b>	0	14	0	2	0	0	0
<b>Criteria</b>	0	40	0	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service and complaint forms are readily available in the foyer. The service has received no complaints for 2017 and 2018 year-to-date. Four residents and family members interviewed advised that they are aware of the complaints procedure. They agreed that the managers are very proactive, and any issues raised are addressed very quickly. All relatives said they had no reason to complain.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The joint managers (one clinical and one administration) confirmed family are kept informed. Four relatives stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management and this was observed on the day of audit. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident</p>



conducive to effective communication.		should they wish to do so. There is access to an interpreter service as required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>All 30 beds at Shalom Aged Care are certified for rest home level of care. On the day of the audit the facility was at full capacity with 30 residents living at the facility and all were under the aged residential care contract.</p> <p>Shalom Aged Care is privately owned. The owner is on-site two days a week and assists with maintenance. Day-to-day operations is delegated to two experienced managers. One manager has been at the facility for nine years. She is employed Monday – Friday and holds an administrative role. The second manager is a registered nurse with a current practicing certificate who has over 30 years of aged care experience. She has been working at Shalom Aged Care for 14 years and works three–four days per week. Both managers have maintained over eight hours annually of professional development activities related to managing an aged care facility.</p> <p>The service has a business plan, which is reviewed annually. The business plan includes; the mission, philosophy, Māori health, quality and risk management, and hazards. The plan is reviewed annually and was currently under review at the time of audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Shalom aged care has an established quality and risk programme. The service employs a non-practicing enrolled nurse to oversee the quality process. The owner is active within the service and is provided with all meeting minutes as well as regular meetings with the two managers.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three caregivers, three registered nurses, one cook, one activities coordinator and the quality staff member) confirmed they are made aware of any new/reviewed policies.</p> <p>Quarterly quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs. The staff interviewed were aware of quality data results, trends and corrective actions. This is an improvement on the previous audit. Other meetings include three monthly infection control meetings, senior management meetings and resident/family meetings.</p> <p>There is an internal audit programme that covers all aspects of the service. Corrective actions are developed, implemented and signed-off as required.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The two managers are responsible for health and safety education, internal audits and accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety</p>

		<p>matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects incident and accident data on forms and enters them into a register. The managers review all incidents and ensure follow-up. Residents with multiple falls are clinically reviewed with one recently transferred to a higher level of care. Incidents and accidents are discussed at the quarterly quality meetings.</p> <p>Six incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process.</p> <p>The managers interviewed could describe situations that would require reporting to relevant authorities. The service has reported two section 31s; one for a wandering resident (now at a higher level of care) and one section 31 for a bomb scare. Following the scare the service conducted a debrief, reviewed the process and practice and updated its policies and procedures.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are policies in place to support recruitment practices. Five staff files were reviewed (two RNs, two caregivers and the quality person). All files contained relevant employment documentation and completed orientations. However, not all staff appraisals were up-to-date. Current practising certificates were sighted for the registered nurses. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>The service commenced on-line training for staff during 2017. A designated lap top has been provided for staff so that they can easily access the training. There is a list of compulsory training each year and staff are expected to access and complete all training on the list. The service maintains a register and follows up staff members who are not managing to keep up with the training. A review of the register documented that staff are completing training. Face-to-face training is also provided for other subjects such as chemical safety and manual handling as examples. A review of all training for 2017 and 2018 year-to-date evidences that all compulsory subjects have been provided over the two years with very good attendance. One of the three RNs have completed interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical manager are able to access external training. Not all staff have an up-to-date first aid certificate. First aid training had already been booked by the service.</p>

<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy aligns with contractual requirements. A minimum of one RN is on-site Monday – Friday. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. An RN is available on-call weekends and after hours and can contact the clinical manager as required for clinical concerns. A quality person also works two to three days a week.</p> <p>The facility manager (non-clinical) is on duty during the day Monday to Friday. The clinical manager works three days a week and there are RNs on duty on the days she is not there. Not all shifts have a staff member with a current first aid certificate (link to 1.2.7.5).</p> <p>Caregivers cover two full shifts and one short shift on AM shifts, and two full shifts for the PM shift and one caregiver on nights.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RNs, and clinical and administration manager, who respond quickly to after-hour calls.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented in the electronic medication system. The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use.</p> <p>A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and caregivers with medication administration responsibilities.</p> <p>Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. Three residents self-administer medicines and have current competency assessments around this. They have access to secure storage in their rooms. Staff check each shift that these residents have safely self-administered their medications and record this on the medication administration sheet.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid</b></p>	FA	<p>All meals are prepared and cooked on-site. The Monday to Friday qualified kitchen supervisor/cook is supported by a weekend cook, relief cooks and a tea cook. All staff have completed food safety training. The service has completed a food control plan that is currently with the local authority for approval. Meals are served directly from</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>the kitchen to residents in the adjacent dining room. Dietary profiles are documented for new residents and the kitchen is informed of any changes to dietary needs. Likes and dislikes are accommodated. Additional or modified foods such as pureed foods, diabetic desserts and vegetarian meals are provided. Residents' weights are recorded routinely each month or more frequently if required.</p> <p>Fridge, freezer and end-cooked temperatures are monitored and recorded daily. Temperatures of meat on delivery are recorded. All containers of food stored in the pantry are labelled and dated. A cleaning schedule is maintained. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans sampled were goal orientated. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary. There were no residents with wounds at the time of audit. Specialist nursing advice is available from the DHB as needed. A physiotherapist is available as needed. Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed. Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs an activities coordinator who has been in the role for 16 months. She is responsible for the planning and delivery of the individual and group activities programme with assistance from the staff. There are organised activities five days per week. The activities coordinator with assistance from the clinical manager completes a resident activity profile on admission and an individual activity plan which is reviewed six-monthly as part of the six-monthly multidisciplinary review.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident's needs. Participation in all activities is voluntary.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and published weekly, and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The group programme includes residents being involved within the community with social clubs, churches and schools.</p> <p>Residents and families commented positively on the activities programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled.</p> <p>The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed, or transferred to the long-term care plan if required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is prominently displayed. Reactive and preventative maintenance is completed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility, including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	<p>FA</p>	<p>The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit. Fourteen residents with bed hoops are included on the enabler register to ensure the service maintains records.</p>

that the use of restraint is actively minimised.		
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## 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)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The service has booked first aid training for staff, as not all staff members have an up-to-date first aid certificate. The service has ensured that the on-call person has a first aid certificate. Staff state that the on-call person (RN) always replies promptly and attends the service as needed. The first aid certificate for the staff member is one month overdue. This risk has been assessed to be low for these reasons. There is a staff appraisal process in place but not all appraisals are up-to-date.	(i)One staff member did not have an up-to-date first aid certificate, this has led to some shifts being without a staff member with a current first aid certificate. (ii) Two of five staff files reviewed did not have an up-to-date appraisal documented	(i)Ensure staff first aid certificates are up-to-date, and (ii) ensure that all staff have an up-to-date appraisal documented.  60 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment,</p>	PA Low	The RNs are responsible for all stages of assessment, care planning and evaluations. Care plans documented were individualised and reflected resident need. However, not all were documented within set timeframes. One of five interRAI	Two of five long-term care plans were not documented within 21 days and one initial interRAI was not completed	Ensure that documentation is in place within set

planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		assessments were not completed within 21 days.	within timeframes.	timeframes.  60 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.