# Devonport Palms Retirement Limited - Devonport Palms

## 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 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:

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| **Legal entity:** | Devonport Palms Retirement Limited |
| **Premises audited:** | Devonport Palms |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 23 August 2018 End date: 24 August 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:** 27

# 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 |
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| | 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 |
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| | 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

Devonport Palms is privately owned and operated, and provides care for up to 30 residents requiring rest home level care. On the day of the audit there were 27 residents.

The service is managed by a facility manager/owner who has worked at the facility for 13 years. The facility manager/owner is supported by a clinical manager. Residents and families interviewed were complimentary of the care and support provided. Staff turnover remains low.

This certification audit was conducted against 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.

This certification audit identified areas for improvement relating to medication management and food temperatures.

## Consumer rights

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| 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. |

The staff at Devonport Palms ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

## Organisational management

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| 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 Cavell group quality management system describes Devonport Palms quality improvement processes. Progress with the quality management programme has been monitored through the three-monthly quality/health and safety/infection control meetings. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is a current business plan in place. Resident/relative meetings are held three monthly. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The internal audit schedule for 2017 has been completed and 2018 is

being completed as per schedule. The service has an annual training schedule for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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| 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 medium or high risk and/or unattained and of low risk. |

Residents and families receive an information pack on admission. The clinical manager completes admission assessments using the interRAI assessment tool. Care plans are developed in consultation with the resident and/or family input. Care plans demonstrate allied health input into the care of the resident. Care plans are reviewed and evaluated at least six-monthly. Medication policies reflect legislative medicine requirements and guidelines. All staff responsible for administration of medicines complete education and medicine competencies. An activities programme is in place. The programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents. Residents expressed satisfaction with the activities provided. All food is prepared on-site. Residents' nutritional needs are identified and documented. Alternative choices are available for dislikes. Meals are well presented.

## Safe and appropriate environment

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| 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 service has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored safely, and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility, including lounge and dining areas. There is a designated laundry and cleaner's room. The service has procedures in place for civil defence and other emergencies and six-monthly fire drills are conducted. External garden areas are accessible with suitable pathways, seating and shade is provided.

## Restraint minimisation and safe practice

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| 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. |

Devonport Palms has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. Staff receive training in restraint minimisation.

## Infection prevention and control

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| 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 control programme and its content are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator role is shared between the clinical manager and team leader/caregiver. The infection control coordinators have attended external training. Staff attend annual infection control education. There is a suite of infection control policies and guidelines that meet infection control standards.

## 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) |
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| **Standards** | 0 | 43 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 1 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br>Consumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with four care staff (three caregivers and one activities coordinator) confirmed their familiarity with the Code. Three residents and five family members interviewed confirmed the services being provided are in line with the Code. |
| Standard 1.1.10: Informed Consent<br>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 | There are established policies/procedures around informed consent and advanced directives. Resuscitation status and advance directives on all files sampled were appropriately signed. There are signed consents for release of information, outings and photographs in all six resident files sampled. Consent is obtained for specific treatments/procedures such as influenza vaccines. |
| Standard 1.1.11: Advocacy And Support | FA | Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information pack provided to residents prior to entry includes advocacy information. The information identifies who the resident can contact to access |

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| Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | | advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members interviewed, were aware of their access to advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br>Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility. |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. The residents and family members interviewed were aware of the complaints process and to whom they should direct complaints. Complaint forms are visible at the entrance of the facility. A complaints register is maintained. There have been no complaints made since the last audit in March 2017. However, a complaint was made through the Health & Disability Commissioner (HDC) in July 2016. The complaint has been reviewed and investigated with corrective actions taken. A letter from HDC in December 2017, confirmed that there would be no further action taken. |
| Standard 1.1.2: Consumer Rights During Service Delivery<br>Consumers are informed of their rights. | FA | The Code and advocacy pamphlets are located at the main entrance of the service. On admission, the facility manager/owner or clinical manager discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are informed about the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, | FA | Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place. Staff receive training on abuse and neglect, which was last completed in June 2018. |

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| privacy, and independence. | | |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>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 | The service has guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there were no residents that identified as Māori. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive training on cultural safety and Treaty of Waitangi, which was last completed in June 2018. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and kept informed and family involvement is encouraged. |
| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | FA | The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The facility manager/owner is responsible for coordinating the internal audit programme. Three monthly staff and three-monthly quality/health and safety/infection control meetings and three-monthly residents meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by management. |
| Standard 1.1.9: Communication | FA | There is a policy to guide staff on the process around open disclosure. Residents and family are |

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| Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | | informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Residents and relatives interviewed confirmed that management and staff are approachable and available. Twelve incident forms reviewed, identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any incidents/accidents. Families are invited to attend the three-monthly resident/family meeting. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available. |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Devonport Palms is owned and operated by a member/director of the Cavell group. The Cavell group is comprised of a group of six independent aged care providers who share policies and provide collegial support while maintaining their independent businesses. Devonport Palms provides care for up to 30 residents requiring rest home level care. On the day of the audit, there were 27 residents in total. All residents were under the aged related residential care (ARRC) agreement.<br><br>The service is managed by a facility manager/owner who is experienced in the industry and has worked at the facility for 13 years. The facility manager/owner is supported by a clinical manager, who has worked at Devonport Palms for 12 years.<br><br>Devonport Palms has a current 2018/2019 business plan that includes goals and objectives. The goals and objectives for 2017/2018 have been reviewed and were documented as being achieved. The business plan incorporates the risk management plan and goals for each area of service delivery and organisational management. The facility manager/owner is responsible for the operational and financial aspect of the business.<br><br>The facility manager/owner has attended at least eight hours of professional development that relates to managing a rest home including NZ Aged Care Association and quality management training courses. |
| Standard 1.2.2: Service Management<br><br>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 | FA | The facility manager/owner reported that in the event of his temporary absence the clinical manager fulfils the role with support from the care staff. |

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| safe services to consumers. | | |
| Standard 1.2.3: Quality And Risk Management Systems<br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The Cavell group quality management system describes Devonport Palms quality improvement processes. Progress with the quality management programme has been monitored through the three-monthly combined quality/health and safety/infection control meeting. The meetings cover matters arising from the three-monthly staff and three-monthly resident meetings, health and safety, complaints, accidents/incidents and infection control, internal audits, and survey results and outcomes. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes for all meetings have included actions to achieve compliance where relevant. Data is collected on complaints, accidents, incidents, infection control and restraint use. Staff interviewed, confirmed they are well informed and receive quality management programme information including accident/incident and infection control data.<br>The internal audit schedule for 2017 has been completed and 2018 is being completed as per schedule. Areas of non-compliance identified at audits have been actioned for improvement. The service has implemented a health and safety management system. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the combined meeting. Hazard identification forms and an up-to date hazard register (last reviewed 19 March 2018) are in place. The service has policies/procedures to support service delivery. An annual resident and relative satisfaction survey (June 2018) has been conducted with respondents advising that they are overall very satisfied with the level of care and service they receive. Falls prevention strategies are in place that includes the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting<br>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 an incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms for the month of June, July and August 2018 were reviewed. All document timely RN review and follow-up. There is documented evidence the family had been notified of any incidents. Discussions with the facility manager/owner confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications lodged since the last audit. |
| Standard 1.2.7: Human Resource Management<br>Human resource management | FA | There are human resources policies to support recruitment practices. Five staff files (one team leader/caregiver, two caregivers, one cook and one activities coordinator) were reviewed. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were |

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| processes are conducted in accordance with good employment practice and meet the requirements of legislation. | | current. A current practising certificate was sighted for the clinical manager. The service has an orientation programme in place to provide new staff with relevant information for safe work practice.<br><br>Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. The clinical manager and caregivers' complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period. The clinical manager has completed interRAI training and has attended education sessions at the district health board (DHB). |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Devonport Palms has a roster in place, which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the residents' needs on different shifts. The facility manager/owner is on-site from 8.30 am until 4.30 pm Monday to Friday and is on-call 24/7 for any operational issues. There is a clinical manager on-site from 7.00 am until 3.00 pm Monday to Friday and is on-call 24/7 for any clinical concerns. The local general practitioner (GP) also provides after hours care if required and the caregivers have access to the local ambulance service.<br><br>The clinical manager is supported by two caregivers on duty on the morning shift, one caregiver on duty on the afternoon shift and one caregiver on the night shift. Additionally, there is one hospitality/caregiver on duty from 8.00 am to 10.00 am on the morning and from 4.00 pm to 8.00 pm on the afternoon to help out with showering and meals. Roster shortages or sickness are covered by casual or off duty staff. The caregivers and residents interviewed reported that there is sufficient staff cover. There are also two caregivers that live directly next door to the facility who are available for any caregiver replacement roles or assistance if required. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, | FA | There is an admission policy and procedure. There is an admission pack, which includes all relevant aspects of service, and family are provided with additional information such as the Health and Disability Code of Rights and how to access advocacy. A needs assessment is required prior to entry to ensure the service can provide the assessed level of care. The clinical manager confirmed that the |

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| timely, and respectful manner, when their need for services has been identified. | | service has good working relationships with the needs assessors, social worker, mental health team and GPs. The admission agreement reviewed aligns with the ARRC agreement. The six admission agreements sighted had all been signed within the required timeframe. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are guidelines for death, discharge, transfer and follow-up. When transferring, all relevant information is documented and transferred with the resident. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification for resident transfers. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Twelve medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. Not all medication charts sampled met legislative prescribing requirements and guidelines. Residents who are prescribed dietary supplements have these correctly prescribed by the GP and staff sign for these as they are administered. Since the last audit the service has implemented an electronic medication management system (Medi-map), however the service also maintains paper medication charts and administration records for those residents who have retained their own GP, and/or where the GP has chosen not to use the electronic system to update the medication prescript.<br><br>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Senior caregivers interviewed described their role regarding medication administration. The service currently uses blister packed medications. Not all medications are checked on delivery against the medication chart. The service no longer uses standing orders. There were no residents self-medicating on the day of audit. The medication fridge temperature is recorded regularly and is within the acceptable ranges. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | All meals provided at Devonport Palms are prepared and cooked on-site. There is a four-weekly seasonal menu which had been reviewed by a dietitian. Meals are plated in the kitchen and delivered to the dining area. Dietary needs are known with individual likes and dislikes documented and accommodated. Pureed and diabetic desserts are provided. Cultural and religious food preferences are met as required. There were no residents requiring pureed meals at time of audit. Supplements are provided to residents with identified weight loss issues (documentation sighted).<br><br>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food |

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| | | services. Residents and family members are satisfied with the food and confirmed alternative food choices are offered for dislikes. Fridge and freezer temperatures are taken and recorded, however the temperatures were not always within range. Dry goods including those decanted from bulk supply, did not always have a date of opening/expiry recorded. The dishwasher is checked regularly by the chemical supplier. All food services staff have completed training in food safety and hygiene and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services<br><br>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 | The clinical manager confirmed that should a consumer be declined entry to the service, the reason for this is recorded and communicated back to the referrer/consumer. Reasons for declining a referral/enquiry may include no bed availability or unable to meet the assessed level of care. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Initial assessments are completed on admission and reviewed as part of the interRAI assessment process. InterRAI assessments have been completed for five of six resident files reviewed (one of the six files, the interRAI file had not yet been transferred to the service by needs assessment service). Risk assessments (within the interRAI assessment tool) have been completed as identified and were reflected in the long-term care plan. The care plans also document the residents' cultural needs, values and spirituality. The activities coordinator completes an activity assessment as part of admission that identifies individual activities and preferences. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long-term care plans were in place for all resident files reviewed and were resident-focused and individualised. Residents and family confirmed they are involved in the care planning process. There is documented evidence of resident and/or family input into care planning and six-monthly reviews. Short-term care plans were available for use to document any changes in health needs. Short-term care plans were evidenced for skin tears, short course antibiotics, chest infections and wounds. To compliment short-term care plans, the service also used treatment plans (ie, UTIs and chest infections).<br><br>Short-term care plans (and where relevant, associated treatment plans) were evaluated at regular intervals and either resolved or added to the long-term care plan if an ongoing problem. Medical notes and other allied health professionals progress notes were evident in the six files sampled. Relatives interviewed were very positive and complimentary about the staff, clinical and medical care |

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| | | provided and confirmed they are kept informed of any significant events and changes in health status. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The caregivers follow the care plan and report progress against the care plan at least daily in the progress notes. During the tour of the facility, it was noted that all staff treated residents with respect and dignity. Residents and families were able to confirm this observation. Caregivers reported that they are informed of any changes in health status at handover between shifts. When a resident's condition alters, the clinical manager initiates a review by the residents GP in the first instance. If external nursing or allied health advice is required, the clinical manager will initiate a referral (eg, to the wound care specialist nurse, podiatrist). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Continence products are available and resident files include a continence assessment, where continence products identified for day use and night use were documented and included in the long-term care plan.<br><br>There were no residents with wounds currently being managed during the audit, however a review of wound records for residents with recently healed wounds showed wound assessment, monitoring and wound management plans had been documented. All wounds had been reviewed within planned timeframes or earlier. There were no residents with pressure injuries on the days of the audit. The care staff have access to specialist nursing wound care management advice through the Cavell group and the local district nursing service. Interviews with the clinical manager and the caregivers demonstrated an understanding of the individualised needs of residents. Documentation evidenced RN oversight of resident care, additional assessments and/or monitoring records (ie, pain assessment, food and fluid monitoring) were sighted. |
| Standard 1.3.7: Planned Activities<br><br>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 | There are two activity coordinators who provide a recreational programme Monday to Friday. The activity coordinators are supported by a qualified diversional therapist (DT) within the Cavell group and they attend the regional DT meetings. The activity coordinators have a current first aid certificate. The activity programme is planned a month in advance and all residents receive a copy of the programme. The group activity programme for the month is also placed on the residents' noticeboards. There are a range of activities to meet the recreational preferences and individual abilities including: word games, history, memorabilia, entertainment, craft, exercises and movies. One-on-one time is spent with residents who choose not to participate in the group programme.<br><br>A mobility van is hired for outings. Residents are encouraged to maintain community involvement and trips are arranged to community groups (eg, church, RSA). Interdenominational church services are held regularly. The activities coordinators complete an activities assessment on admission. Each |

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| | | resident has an individualised activity plan documented within three weeks of admission. All activity plans sampled had been reviewed at least six-monthly against the stated goals. Resident meetings provide an opportunity for the residents to provide feedback and suggestions on the activity programme. |
| Standard 1.3.8: Evaluation<br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Four long-term care plans (for residents who had been in the service six months or longer) had been evaluated six monthly or earlier due to health changes. Short-term care plans focus on short-term issues and are reviewed regularly with ongoing problems transferred to the long-term care plan. Written evaluation forms are used to document achievement (or not), of the residents' goals. The six-monthly review is completed with input from the multidisciplinary team (clinical manager, GP, team leader/caregiver, activities coordinator and member of the family or resident as appropriate). |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br>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 | Referral to other health and disability services is evident in the sample group of residents' files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Discussion with the clinical manager identified that the service has access to GPs, ambulance/emergency services, allied health professionals, needs assessors and mental health services for the older people. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br>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 is a waste and hazardous substances safety policy. Education on the management of waste and hazardous substances is provided during orientation of new staff and as scheduled on the education planner. All chemicals are correctly labelled and are stored in locked cupboards. Safety datasheets and product wall charts are available. Gloves, aprons and goggles are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties. |
| Standard 1.4.2: Facility Specifications<br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit | FA | The building holds a current warrant of fitness, which expires in January 2019. There is a lift and stair access between the two floors. The lift can accommodate a bed/ambulance stretcher. Contractors who are available 24/7 carry out reactive and preventative maintenance as organised by the facility manager/owner. There is a planned maintenance programme. Hot water temperatures of all resident areas are monitored two monthly and are maintained below 45 degrees Celsius. |

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| for their purpose. | | The living areas are carpeted, and vinyl surfaces exist in bathrooms/toilet areas. The corridors are wide enough to promote safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are external areas and gardens, which are easily accessible. There is outdoor furniture and seating with shade provided. The staff interviewed stated that they have all the equipment referred to in care plans to provide care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br>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 | There are adequate numbers of communal toilets and showers for residents in rooms without ensuites. Other bedrooms have either single or shared ensuites. All bedrooms have hand basins. There is appropriate signage, easy to clean flooring and fixtures and handrails appropriately placed. Privacy is maintained at all times (observed). |
| Standard 1.4.4: Personal Space/Bed Areas<br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Bedrooms are single with the exception of six double rooms. The rooms are spacious enough for the resident to easily manoeuvre around with mobility aids as required. Residents are encouraged to personalise their rooms as desired. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large open plan lounge on the ground floor with access to the outdoor area. The upstairs area has a lounge with kitchenette, which allows for small group or individual quiet time and family visits. There is a separate resident dining room. All lounge/dining areas are easily accessed. Residents are able to move freely and safely, and furniture is arranged to facilitate this. There is adequate space to allow for individual and group activities to occur within the lounges. |
| Standard 1.4.6: Cleaning And Laundry Services<br>Consumers are provided with safe | FA | There is a cleaning policy and cleaning schedules are in place. Personal protective equipment is available in sluice/cleaning and laundry rooms. There is a defined clean/dirty area within the laundry. There were adequate linen supplies sighted. The cleaning trolleys are stored safely when not in use. |

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| and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | | Safety datasheets are available for cleaning and laundry staff. Staff were observed to be wearing appropriate protective wear when carrying out their duties. Cleaning and laundry audits have been completed. Residents expressed satisfaction with the cleaning and laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service dated 17 June 2000. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 20 June 2018. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including sufficient food, water (water tank supply) and alternate gas cooking (BBQ and gas hobs in the kitchen).<br><br>There are civil defence, pandemic outbreak supplies and first aid kits available, which are checked six monthly. Emergency equipment is available at the facility. There is the availability of a generator to hire if needed. Short-term backup power for emergency lighting is in place for up to four hours. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. The clinical manager holds a current first aid certificate. There is a call bell system in place and there are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas are well ventilated and light. The facility has ceiling heating. The temperature is monitored (visual display) by the facility manager. Each bedroom is individually thermostat controlled. |
| Standard 3.1: Infection control management<br><br>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 | FA | The infection control coordinator role is shared between the clinical manager and the team leader/caregiver. The infection control position description clearly defines responsibilities. There are three monthly provider group (Cavell group) combined infection control and health and safety meetings. Meeting minutes are available to staff. The infection control programme is reviewed annually. Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. |

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| the service. | | |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control is managed by the site's infection control coordinators and monitored with support by the Cavell group infection control committee. The infection control coordinators have attended external education on infection control. The infection control coordinator has access to the Cavell groups infection control coordinator, DHB infection control nurse, public health, and GP and laboratory personnel as needed. |
| Standard 3.3: Policies and procedures<br><br>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 | The infection control manual outlines a range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinators are responsible for coordinating/providing education and training to staff. Infection control education occurs regularly throughout the year. All newly appointed staff receive infection control education on orientation. Hand hygiene audits are completed at least annually for all staff. Resident education occurs as part of providing daily cares and is discussed as relevant at resident meetings. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the | FA | Policies and procedures document infection prevention and control surveillance methods. Definitions of infections are in place and appropriate to the complexity of service provided. The surveillance data is collected throughout the month and analysed monthly to identify areas for improvement or corrective action requirements. Data is reported to and benchmarked monthly with other facilities in the Cavell group infection committee. Infection rates have remained low. Any trends identified, including quality initiatives are discussed at both the Cavell group management meeting and site staff |

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| infection control programme. | | meetings. Infection control internal audits have been completed. There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation<br>Services demonstrate that the use of restraint is actively minimised. | FA | Devonport Palms has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint free environment. Staff receive training in restraint minimisation, which was last completed in November 2017. |

# 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) |
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| Criterion 1.3.12.1<br><br>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine | PA Moderate | The service has documented policies and procedures for safe medication management. All staff who administer medication have completed the required medication competencies. Medication is stored safely. Reconciliation of medication has not always been completed. The service uses an electronic medication management system, however not all medication changes are being documented in the electronic medication chart. At times, paper administration records are also being maintained. Medications, including short course medication have been administered without a signed prescription. The medication charts reviewed, identified that the GP has reviewed all residents’ | i) Medicine reconciliation of received medications with the resident’s medication chart had not been accurately completed for three out of 12 files.<br><br>ii) In two of twelve files, staff had administered medications without a documented prescription. There was also evidence of transcribed medication changes as per a MHSOP clinic letter in one of the two files. Note: The resident was in hospital during the audit and the service was advised that the resident now required a higher level of care and has since been discharged from their service.<br><br>iii) One of twelve files evidenced administration of a short course medication after the prescribed timeframe. Note: The service had followed this up with the resident’s GP during this audit and was awaiting changes to be made to | (i) Ensure that all medicines when received are reconciled with the resident’s current medication chart.<br><br>(ii) Ensure that medications are only administered with a signed |

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| reconciliation in order to comply with legislation, protocols, and guidelines. | | medication three-monthly and all allergies are noted. | the electronic medication chart.<br>iv) Staff had been administering medications from a new pharmacy printed medication chart for one of twelve residents. The chart had been supplied nine days earlier and had not yet been signed by the residents GP. For this same resident, staff had continued to administer a controlled drug now prescribed for daily use (also nine days earlier), from a copy of a controlled drug prescription, however there was no documented record of administration. This change to daily use had not been included on the pharmacy printed medication chart. Note: The service followed this up with the pharmacy and GP during the audit and a complete and current signed medication chart and updated printed administration sheet was provided (sighted). Since the draft report, the service has reported that all clients received their medication as prescribed and corrective actions have now been sighted and signed-off by the local DHB. Therefore the risk has been lowered to moderate. | prescription and that medication changes are documented on the medication chart by the residents GP in a timely manner.<br>(iii) Ensure end dates of short course medications are documented and followed.<br>(vi) Ensure medications are all signed for and administration including time given is clearly documented<br><br>7 days |
| Criterion 1.3.13.5<br>All aspects of food procurement, production, preparation, | PA Low | Food is purchased and delivered weekly to the service. Food preparation benches have been covered with stainless steel, to ensure surfaces are able to be thoroughly cleaned. Temperatures of delivered chilled food and end-cooked food are not consistently recorded as per the | i) Temperatures of delivered chilled food (ie, milk & fresh meat, and end-cooked food) were not consistently recorded as per the organisations policy and procedures.<br>ii) Fridge temperatures were recorded daily, however temperatures were consistently documented as -ve 0 to -ve 4 degrees Celsius and there was no documented evidence of this having been reported to management, or | i) Ensure that temperatures of incoming chilled food and end-cooked hot food are |

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| storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | | organisations policy and procedures. Fridge and freezer temperatures were consistently recorded; however, the temperatures were not always within range. Dry goods including those decanted from bulk supply did not always have a date of opening/expiry recorded. | evidence of corrective action. It is noted that food kept within these fridges was not frozen.<br><br>iii) Not all dry goods stored in the pantry(s) including those decanted from bulk supply from original packets, had evidence of dates when opened or expiry (eg, milk powder, spices, sugar, dried pasta). Two items stored in the pantry had also expired according to manufacturer's label. | recorded as per policy.<br><br>ii) Ensure that corrective actions to address temperatures out of range are documented and implemented.<br><br>iii) Review current practice of decanting dry goods to ensure opening/expiry dates are clearly visible.<br><br>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.

| No data to display |
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End of the report.