

Goodwood Park Health Limited - Seadrome Home and Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Goodwood Park Health Limited
Premises audited:	Seadrome Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 2 October 2018 End date: 4 October 2018
Proposed changes to current services (if any):	Seadrome is being purchased by Goodwood Park Healthcare Limited.
Total beds occupied across all premises included in the audit on the first day of the audit:	42

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.

General overview of the audit

Seadrome Home and Hospital provides hospital and dementia levels of care for up to 45 residents. The service is being purchased by Goodwood Park Health Limited, with this audit conducted to assess the prospective provider's preparedness to provide health and disability services in aged residential care. The audit was also to assess Seadromes current level of compliance against the Health and Disability Service Standards and the service's contract with the District Health Board. There have been no significant changes to the facility or services since the last audit.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with family/whanau, management, staff and the general practitioner. Goodwood Park representatives were present during the audit.

The audit resulted in five areas requiring improvement. This is with regard to advance directives/resuscitation orders, the quality programme, medicine management, first aid and interRAI assessments.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and family/whanau on admission. The residents' privacy, independence and personal safety is protected. Care and support are provided in a manner which recognises the residents' culture, values and beliefs. Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a Maori health care plan and other related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles.

Communication is open and resident choices are recorded and acted upon. Adequately documented processes are in place for informed consent. Some residents and family/whanau are assisted and encouraged to formulate advanced directives. Advocacy information is available for residents and family/whanau. Links with family/whanau and the community are encouraged and supported by the service provider. Complaints are managed in line with consumer rights legislation and a complaint register is maintained.

The Goodwood Park representatives interviewed demonstrated knowledge of their responsibilities under the Code.

Organisational management

The organisation is currently governed by the directors/owners. Day to day operations are the responsibility of an experienced facility manager, and an assistant manager. Organisational performance is monitored. The mission and strategic goals are documented and reviewed.

Quality and risk management systems support service delivery. Quality data is collated and measured. The required policies and procedures are documented, reviewed and controlled. Quality data is communicated, and improvements made when required. Adverse events are well managed.

Staffing meets the needs of the services delivered. There is an in-service education programme. Competencies are assessed, and performance is monitored.

Resident records are integrated and maintained in a secure manner. Entries in records meet best practice standards for the management of health records.

Continuum of service delivery

Assessments and care plans are completed and evaluated by the nursing team. Activities plans are completed by the registered nurses in consultation with the occupational therapist (OT) and diversional therapist (DT). Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, family/whanau expressed satisfaction with the activities programme in place.

Medications are managed and administered in line with the sighted medication management policy. Medications are monitored and reviewed as required by the general practitioner (GP). The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for. Snacks and drinks are available 24 hours for residents if needed.

Safe and appropriate environment

All building and plant comply with legislation with a current building warrant of fitness in place. Equipment and electrical checks are conducted. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The dementia area is secure with large, safe areas for residents to wander.

Cleaning and laundry services are of an acceptable level. These services are monitored to ensure they continue to meet the needs of the residents.

Essential emergency and security systems are in place. There is an approved fire evacuation plan and emergency drills are conducted as required. Call bells allow residents to access help when needed.

Restraint minimisation and safe practice

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in the management of challenging behaviours.

The dementia area is secure. There is key pad entry to the grounds which enables visitors to come and go as they please.

Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Infection control education is provided as part of orientation and on-going educational programme. Infection data is collated monthly by the charge nurse (CN) and analysed by the facility manager who compiles infection reports which are reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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	40	0	4	1	0	0
Criteria	0	87	0	4	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Interviewed staff demonstrated knowledge of the Code of Health and Disability Services Consumers` Rights (the Code). The Code is included in staff orientation and in the staff training education programmes. On the days of the audit, staff demonstrated knowledge of the Code when interacting with residents. The family/whanau reported that staff respect their rights and are incorporated as part of their everyday practice.</p> <p>Goodwood Park has been working in the health and disability sector for many years and demonstrates a good understanding of consumer rights legislation.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>Policies and procedures on consent support the residents` right to make informed decisions. The quality/clinical nurse representative reported that informed consent is discussed and recorded at the time the resident is admitted to the facility. The residents' files sampled had the required consent forms signed where appropriate, by the enduring power of attorney (EPOA). These had been activated. Staff acknowledged the residents` right to make choices based on information presented to</p>

		them. Family/whanau interviewed confirmed that residents were provided with day to day choices and consent was obtained. An improvement is required to formalise the process regarding advanced directives/resuscitation orders.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	There were appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. 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 training on the right to advocacy / support is provided annually and staff demonstrated understanding of how residents can access advocacy/support persons.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	There are no set visiting hours and family/whanau are encouraged to visit at any time. Family/whanau 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.
<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>Information about the complaints process is provided to residents and family on admission. The process and forms are accessible. Interviews with family/whanau confirmed awareness regarding their right to make complaint.</p> <p>Records sampled confirmed effective and timely handling of any verbal concerns. A full investigation is completed, and the concerned party is notified of the outcomes. Apologies are made if required.</p> <p>The complaints register is utilised for any formal complaints. The register includes the date, nature of complaint, action taken and resolution. The register also provides evidence of transparency, apologies and open disclosure. There have been no formal (written) complaints since the last certification audit and none reported to the</p>

		Health and Disability Commissioner or the district health board.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and information about the Code, advocacy services and the complaints process are provided on admission and displayed at the facility. The quality/clinical nurse representative reported that an advocate visits the service and can be accessed as required. Family/whanau interviewed were aware of their rights and confirmed that information was provided to them during the admission process. Seadrome information pack was sighted and outlines the services offered. Signed residents' agreements were sighted and meet the requirements of this standard and district health board requirements.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The privacy and dignity policy explain 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 residents' individual beliefs and values. All rooms are single occupancy, which maintains physical, visual, auditory and personal privacy. Residents' personal belongings are maintained in a secure manner. There are documented policies and procedures on abuse and neglect including the required reporting process.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Maori perspective on health is documented and includes Maori models of Health and barriers to access. End of life care and death of the Maori resident is included. Cultural needs are included in the care plans that meet the individual's needs. There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. The organisation maintains contact with the local Iwi. Cultural safety training is provided to all staff. The Code is available in Maori and satisfaction surveys include cultural and spiritual beliefs.

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Cultural needs are determined 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 accordance with the principles of the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident. Residents' values and beliefs are discussed and incorporated into the care plan. Family/whanau members interviewed confirmed they are encouraged to be involved in the development of the person-centred long-term care plan. In interviews conducted, staff demonstrated an understanding of cultural safety in relation to care.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Policies sighted evidence 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 is included in the employment and orientation process.</p> <p>Interviews, with family/whanau, and observation during the audit, indicated that residents are free of any form of coercion or discrimination. The quality/clinical nurse representative interviewed demonstrated awareness of the importance of maintaining professional boundaries and processes they are required to adhere to.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There are systems in place to ensure staff receive a wide range of opportunities which promote good practice within the facility. Staff reported that they were 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. The nursing team is available and accessible to care staff for clinical support and advice when required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Staff education has been provided related to appropriate communication methods. The service has the required access to interpreting services</p>

<p>provide an environment conducive to effective communication.</p>		<p>for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documentation regarding open disclosure following incidents/accidents was evident. Family/whanau reported that they are informed of any events or concerns.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation is currently governed by two directors/owners. The mission and goals are displayed at the front entrance of the facility. Goodwood Park Healthcare Limited is in the process of purchasing the business. It was reported that the requested information regarding the purchase and transfer has been forwarded to the required authorities.</p> <p>Organisational performance is monitored in an ongoing manner. The facility manager has been meeting with one of the directors on a weekly basis to discuss business performance. The facility manager is a registered nurse and has been in the position for 28 years. The facility manager has previous experience in the care of older people and dementia and maintains training hours in management and nursing scope of practice. The facility manager is supported with day to day operations by the administrator, the assistant manager, and the newly appointed quality/clinical coordinator.</p> <p>Goodwood Park has been providing residential health services for many years. Their current scope of services includes brain injury and mental health. This is their first venture into the aged residential care sector. An established governance structure is in place. Two of the Goodwood Park board members were present and interviewed during the audit. There are four directors. Two of the board members have a clinical background, one is a chartered accountant and the other has a legal background. The name of the legal entity will be Goodwood Seadrome Limited which has been incorporated. The general manager for Goodwood Healthcare will become the operational manager at Seadrome.</p> <p>Goodwood Healthcare governance have conducted a comprehensive due diligence process prior to the offer of purchase. The purchase agreement is now unconditional subject to transfer of the district health board contracts. The sale includes land, buildings and chattels. A transition plan was sighted. This includes responsibilities and</p>

		<p>timeframes for the transition. There are no proposed changes to the service, other than refurbishment and upgrading facilities.</p> <p>Seadrome currently provides a secure unit of 25 beds for residents with dementia who are able to mobilise independently, and 20 hospital beds for residents with dementia who are unable to mobilise independently. There were 42 residents at the time of audit, 23 in the dementia unit and 19 in the hospital. Two residents were under the age of 65 years (one in the dementia unit and one in the hospital). Additional contracts are held with the district health board for the provision of respite and day stay services.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>It is reported that the current facility manager will remain and will meet/report to the operational manager weekly, who reports directly the board. The Goodwood operational manager is an experienced registered nurse, previous district health board portfolio manager, charge nurse and dementia liaison advisor. The operational manager was present and interviewed during the audit. A position description for this role is currently being drafted.</p> <p>A registered nurse (previously the assistant manager at Seadrome) continues to fulfil the role of the facility manager during a temporary absence and has been working at Seadrome for the past 19 years. The facility manager is also now supported by the quality/clinical representative who is an experienced registered nurse with a background in aged residential care.</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>	PA Low	<p>A quality and risk management framework is defined. This includes a description of quality related activities including the quality cycle to continually review and improve services, however an improvement is required to ensure all quality activities are being implemented as required. A designated quality/clinical representative has recently been appointed and is on site three days per week. The quality/clinical representative position description includes the required activities and responsibilities.</p> <p>Organisational policies and procedures reflect standards, contracts, best</p>

		<p>practice, legislation requirements and are readily available to staff. All policies are subject to reviews and all policies sampled were controlled documents. This is now the responsibility of the quality coordinator. The Goodwood board members and the operational manager reported the policies and procedures will remain consistent, until their next review date, at which point they will be amended to reflect the Goodwood 'flavour'.</p> <p>Internal audits are completed against the schedule as required. These cover the scope of the organisation.</p> <p>A risk management programme is in place. This includes health and safety policies and a health and safety plan. The health and safety programme is currently under review to better reflect changes in the current legislation and combine with Goodwood. There is a hazard/risk management programme which is also being updated as part of the health and safety review. Business, clinical and financial risks are monitored.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The current facility manager and the Goodwood operational manager were both aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, missing persons and completion of Section 31 notifications to the Ministry of Health.</p> <p>It is reported that the service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff receive education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Individual incident reports were sampled. Each incident report had a corresponding note in the progress notes to inform staff of the incident. The required notifications were made. Emergency actions and follow up investigations were completed.</p> <p>All incidents are entered onto a register. This enables management to</p>

		track actions and status. Adverse events are collated monthly and discussed at nurse management meetings.
<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>	FA	<p>Human resource processes are implemented in line with good practice and employment legislation. The facility manager is responsible for the recruitment, orientation and performance review process. The assistant manager is an assessor and ensures all staff have the required levels of dementia training.</p> <p>All registered nurses and managers hold current annual practising certificates. Evidence of visiting practitioners' practising certificates is also maintained. All staff have an orientation which includes the essential components of service delivery. This includes training on clinical emergencies, competencies and the management of challenging behaviour. Staff who administer medications have the required competency assessments. All staff complete the required unit standards on dementia. An induction process is also implemented for casual/agency staff.</p> <p>A wide variety of in-service education is provided. Education and training hours exceed eight hours a year for each staff member. Staff confirmed they have access to sufficient training opportunities. Education is also provided by external parties. This includes regular education from the district health board gerontology nurse and the visiting nurse practitioner. The topics provided are relevant to the services provided and the residents clinical needs.</p> <p>Staff performance is monitored, and annual performance appraisals were sighted in records sampled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	PA Low	<p>There is a documented staffing rational. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy. There was always at least one registered nurse on all shifts in the hospital and an experience team leader in the dementia unit. There are three to four health care assistants in the</p>

		<p>dementia unit during the day and two during the evenings and at night. There is one registered nurse and two healthcare assistants in the hospital during the day, and one nurse and one health care assistant during the night.</p> <p>The facility manager is a registered nurse and is on site five days per week. The assistant manager is on site two days per week and the quality coordinator is onsite three days per week. Both are registered nurses. Additional staff include administration and housekeeping. The roster also identifies additional staff who are orientating.</p> <p>An improvement is required regarding first aid certificates for staff.</p> <p>The Goodwood board members interviewed reported that there will be no change to the roster and the current staff numbers will remain the same.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The admission process provides verification and documentation of individual resident information. Daily resident lists are maintained. Access to electronic records is guarded by an individual password. Electronic data is backed up nightly and held securely off site.</p> <p>Resident files are stored securely in the nurses' station in both the dementia unit and hospital area. Sample of resident records indicated they include reports from all health professionals. Daily progress notes are maintained, and records are integrated in the one file. Entries are legible, dated, signed and designated. A specimen signature list is maintained.</p> <p>Archived records are stored securely and maintained for 10 years at which point they go into the secure document destruction bin</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Seadrome Home and Hospital's welcome pack contains all the information about entry to service. The policy has all the required aspects of management of enquiries and entry. Assessment and entry screening processes are documented and clearly communicated to family/whanau of choice where appropriate, local communities and</p>

		<p>referral agencies.</p> <p>The entry to service process was conducted within the required time frames and were signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medications are stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the RNs when the resident is transferred back to the service. All medications are reviewed every three months and as required by the GPs. Allergies are clearly indicated, and photos current for easy identification.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. A charge nurse and health care assistant were observed administering medicines following the required medication protocol guidelines and legislative requirements in the hospital and dementia wing respectively.</p> <p>There were no residents self-administering medications at the service and a self-administration medication policy is in place if required. Improvements are required in ensuring six-monthly controlled drug stock takes and medication fridge temperature monitoring.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met</p>	FA	<p>Meal services are prepared on site and served in the allocated dining rooms. The menu has been reviewed by the registered dietitian. Diets</p>

<p>where this service is a component of service delivery.</p>		<p>are modified as required and the cooks confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night on a 24-hour period. The family/whanau interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was audited and registered under the food control plan. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The quality/clinical nurse representative reported that all consumers who are declined entry are recorded. When a consumer is declined entry, family/whanau and the consumer are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial assessments are completed within the required time frames on admission. Care plans and interRAI assessments are completed (refer standard 1.3.3.3). Assessments and care plans are detailed and are completed in consultation with the family/whanau and other health team members as appropriate. In interviews conducted, family/whanau expressed satisfaction with the assessment process in place.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans sampled were resident focussed, integrated and provide continuity of service delivery. Care plans included the required interventions that addresses the outcomes identified by the ongoing assessment process. Behaviour management plans include triggers and</p>

		<p>interventions. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in short term care plans and person-centred long-term care plans were sufficient to address the residents' assessed needs and desired goals/outcomes. The files sampled specified prevention-based strategies for minimising episodes of challenging behaviours and described how the residents' behaviours were managed over a 24- hour period. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift.</p> <p>Adequate clinical supplies are available, and the staff confirmed they have access to enough supplies. Family/whanau members interviewed reported satisfaction with the care and support their families/whanau are receiving.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' files sampled reflects their preferred activities and are evaluated every six months or as when necessary. 24- hour activities are addressed in person-centred long-term care plans to manage residents with behaviours of concern. The DT and OT develop an activity planner for hospital, dementia and under 65 years. The DT has oversight on activities on the hospital wing conducted by healthcare assistants. Residents' activities information form is completed in consultation with the family during the admission process. Residents who identify as Maori along with other staff members sang, sang waiata and conducted a karakia for the auditors.</p> <p>The residents were observed to be participating in a variety of activities on the audit days. There are planned activities and community</p>

		connections that are suitable for the residents. There are regular outings for all residents (as appropriate). Family/whanau interviewed reported overall satisfaction with the level and variety of activities provided.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Residents' person-centred long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the GP and nursing team.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are documented processes for handling waste and hazardous substances. Processes for the collection, storage and disposal of biomedical waste, household rubbish and recyclables are in accord with infection control principles and comply with local body requirements. Contenance products are added to the skip and removed three times a week.</p> <p>Cleaning staff have received training in the handling of chemicals and hazardous waste. Chemicals are delivered by an external provider. Chemicals are accessed through a closed chemical dispensing system. Secure storage is provided. Safety data sheets are available in the laundry and cleaner's room. Personal protective equipment is provided and observed to be used by staff. General waste management audits are routinely conducted.</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>There is a planned maintenance programme. There is a maintenance inspection checklist with evidence that maintenance concerns are identified and followed up in a timely manner. A maintenance request record book is maintained. Furnishings, fittings and floorings are maintained and suitable for the care and support of residents. Applicable building regulations and requirements are met. There is a current building warrant of fitness which expires in September 2019.</p> <p>Large, well-furnished lounge and dining areas are provided. There is sufficient space for the use and storage of mobility aids. Sufficient equipment and supplies are available. The hoists and weighing scales are functionally maintained. Medical equipment is calibrated annually. Electrical equipment is tested. Residents are transported to external appointments and events in a van with current registration and warrant of fitness.</p> <p>Enclosed gardens and safe, sheltered external areas with suitable seating is available. Mobile residents are protected from traffic on the driveway by a key coded gate with a further key coded gate at the exit on to the road. There are paved pathways for residents to walk in the grounds and there are ample safe areas outside for residents to wander.</p> <p>Goodwood board members stated their intentions to commence a refurbishment programme to upgrade the facility and have no other intentions to change the buildings.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>There are sufficient individual toilets and bathrooms provided. Some bedrooms have ensuite. Bathrooms are well lit, fitted with hand rails, non-slip flooring and call bells. Finishing materials are waterproof. Reversible door catches and privacy curtains are installed in each bathroom. Hot water is monitored routinely, where a variation occurs this is followed up. All staff carry hand gel and there is a hand basin in each room.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There are sufficient bedrooms to accommodate 25 residents in the rest dementia area and 20 residents in the hospital. There are three shared rooms in the dementia area. This has been approved by family members. Rooms used for hospital residents are of sufficient size to accommodate residents requiring hospital level care, allowing for mobility aids, equipment and staff caring for the resident. Electric beds are provided for hospital residents. There is adequate room in all bedrooms for personal possessions. Each bed space is provided with a wall light and a nurse call bell. Family/whanau interviewed confirmed that bedrooms were adequate for their family members needs and that personal space is respected.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are separate well-furnished lounges and dining areas for the hospital and the dementia area. Activities are provided in the lounge areas and in a separate recreation room. Alternative additional small sitting areas are available in each area. The communal areas are sufficient to accommodate all the residents. There is a variety of seating to suit all needs. There is room to accommodate wheelchairs and walkers. Family/whanau confirmed that the lounges and dining areas meet their needs. Surveys provide residents/family with the opportunity to provide feedback regarding the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry services are provided on site in an area that is fit for purpose. The laundry room has good separation of clean and dirty areas and laundry processes meet good practice guidelines. Maintenance, functional testing and temperature records sighted indicate the laundry processes meet infection control standards. Interviews with staff and family indicate satisfaction with facility cleanliness and the state of linen and personal clothing.</p> <p>Cleaning services are provided by employed staff. Internal audit records and visual inspection indicate that cleaning meets infection control requirements and is of a high standard. A well-equipped cleaning trolley with secure storage for chemical containers and a secure cleaning room is provided. The cleaners are trained in the use of equipment and</p>

		<p>chemicals. Documented material safety data sheets are available in work areas.</p> <p>Management monitors cleanliness and laundry standards through observations, resident/family feedback and internal audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is a current approved evacuation scheme. There is evidence in training records that fire and evacuation training has been provided twice in the last 12 months. There is a pandemic response plan and sufficient supplies in the event of a civil defence emergency. All staff are trained in emergency management. A monthly fire safety checklist is routinely completed. This includes signage and an emergency equipment checklist.</p> <p>All bed spaces, bathrooms and toilets have a nurse call bell. These were seen to be within easy reach of the resident. The location of the call shows on electronic light boards in the dementia unit nurses' station and the lounge and corridor in the hospital. Functional checks are undertaken monthly. There are emergency call bells in the dementia area.</p> <p>A suitable security policy and lock down process is in place. The entire grounds are secure with key pad entry.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility has plenty of natural light. All bedrooms have at least one good sized window that opens and some have doors to the garden. There is plenty of natural ventilation. The hospital wing has under floor heating with thermostat controls in each bedroom. There is wall mounted electric panel heaters in communal rooms, corridors and bedrooms in the dementia area. Observations during the audit and interview with family/whanau members indicated that the internal environment is maintained at a comfortable temperature. A small sheltered area away from the main building is available for residents who smoke.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The charge nurse has access to external specialist advice from the GP and DHB infection control specialists when required. There is a documented role description for the infection control coordinator including role and responsibilities.</p> <p>The infection control programme is approved and reviewed annually. Infection rates are discussed at staff meetings. Staff are made aware of new infections through daily handovers on each shift. The infection control programme is appropriate for the size and scope of the service.</p> <p>There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Collation, analysis and reporting of infection are discussed and explained at the management and staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The service has documented policies and procedures in place that reflect current best practice. Policies have been reviewed and include standard notification section 31. Staff were observed to be compliant with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by the charge nurse, facility manager and other specialist consultants. A record of attendance is maintained and was sighted. The training content meets best practice and guidelines. The infection control coordinator attended infection control training conducted by the service specialist consultant to keep their knowledge current. External contact resources included: GP, laboratories and local district health boards. There is an understanding of outbreak management where visitors will be warned of any outbreak and advised to stay away until contained. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>Surveillance of infections is carried out according to the infection control programme. The infection control coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. All infections are recorded on the infection report form, this information is collated and reviewed and analysed by the infection control coordinator and facility manager who will advise staff and management of the outcome.</p> <p>Analysis includes identifying trends and comparisons against the previous years. The GP is notified if there is any resistance to antimicrobial agents and evidence of GP involvement and laboratory reporting was sighted. Surveillance programme is reviewed during the infection control programme review.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Seadrome home and hospital is committed to minimise the use of restraint in the clinical setting, whilst maintaining safety for residents and staff. The restraint minimisation policy provides consistent definitions for restraints and enablers and they define the secure gate at the entrance to the facility as an environmental restraint. No residents were using restraint or enablers on the day of the audit at the service. All staff receive education regarding restraint minimisation and challenging behaviour.</p>

		Goodwood Park representatives interviewed demonstrated a clear understanding of the use of restraints, enablers and are well versed in the management of behaviours of concern.
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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 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	<p>The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives however some of the files sampled had no copies of advance care planning/resuscitation orders in place.</p>	<p>Decisions regarding advanced directives/resuscitation orders have not been clearly formalised.</p>	<p>Formalise the process regarding advanced directives/resuscitation orders</p> <p>90 days</p>
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>There is evidence that some of the required quality data is discussed during weekly nurse management meetings. These include a range of discussions regarding clients, incidents, audits, health and safety, infection control etc and are providing an effective method for monitoring and managing clinical risk.</p> <p>The internal audit process is implemented. A wide range of audits are being conducted with high risk activities audited more</p>	<p>Not all components of the quality management system have been maintained.</p>	<p>Implement all requirements of the quality management system</p> <p>90 days</p>

		frequently. It is reported that where a short fall is identified, that this is discussed with the facility manager and rectified as required. There was some evidence that this is occurring, however the main venue for discussing corrective actions and achievement towards quality goals was previously quality meetings, and these have not been maintained.		
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	Rostering numbers are sufficient, all staff have training on emergency management and there is an experienced registered nurse on each shift, however the health and safety policy requires a staff member with a current first aid certificate to be on each shift. This has not been maintained.	The internal requirement to have a staff member with a current first aid certificate on each shift has not been maintained.	<p>Provide evidence that there is a staff member with a current first aid certificate on each shift.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A 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.</p>	PA Moderate	Weekly controlled drug stock takes are conducted, and all medications are stored appropriately however six-monthly stock takes and monitoring of medication fridge temperatures were not being conducted to comply with legislation, protocols, and guidelines.	Not all medication requirements have been maintained. For example, medication fridge temperature monitoring and six-monthly controlled drug checks.	<p>Conduct the required controlled drug checks every six months. Monitor the medication fridge temperature</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision,</p>	PA Low	InterRAI assessments are completed however not all expected timeframes have been met and care plans are reviewed every six months or when there is any noted significant change in the condition of a	Not all interRAI assessments have been completed within the required timeframes.	Complete interRAI assessments within the required timeframes.

evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		resident.		60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.