# Capella House Limited - Capella House

## Introduction

This report records the results of a Partial 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Capella House Limited

**Premises audited:** Capella House

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 24 June 2020 End date: 24 June 2020

**Proposed changes to current services (if any):** The upper level of the building has been converted to make nine single and one double bedroom to increase the hospital level of care by 10 beds. This will change the reconfiguration to a maximum 39 beds (19 dementia beds, 20 hospital level of care beds).

**Total beds occupied across all premises included in the audit on the first day of the audit:** 29

# 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

Capella House provides rest home, hospital and secure dementia care services for up to 29 residents. With the reconfiguration, bed capacity will increase to 39 residents. The partial provisional audit was conducted to establish the level of preparedness of the provider to reconfigure the service to add 10 new hospital level of care beds.

The service is family owned and operated and there have been no changes in management since the last audit. The partial provisional audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board (DHB). This audit confirmed the provider was prepared to provide additional hospital services. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner (GP).

There was one area identified requiring improvement relating to having an approved fire evacuation plan prior to occupancy of the new area.

## Consumer rights

Nil

## Organisational management

Capella House is a family owned and run service. There is a clearly documented and displayed organisation’s mission, vison and philosophy. The direction and objectives of the service are monitored both formally and informally through the business planning documents. There is a transitional plan to reconfigure the 10 new hospital level of care beds.

The service is managed by a suitably qualified and experienced facility manager. The facility manager is responsible for overall day to day operations of the facility. The facility manager is supported by the clinical nurse manager (CNM). Monitoring of the services provided is regular and effective.

The service has sufficient staffing numbers for the commencement of the new level of care requirements. The documented human resources management system provides for the appropriate employment of staff and on-going training processes. A system has been developed for the orientation, induction and ongoing education programme.

## Continuum of service delivery

Planned activities are appropriate to the residents’ assessed needs and abilities. The service’s medication management system is in place and follows required policies and procedures for safe medicine management practice. Staff who administer medications have completed annual competences. All medications are reviewed by the GP every three months.

Nutritional needs are provided in line with nutritional guidelines. Individual and special dietary needs are provided when needed. Snacks are provided to residents throughout the day and night if needed in the dementia unit.

## Safe and appropriate environment

The service has renovated an upper level area to add 10 new hospital level of care rooms. Cleaning and laundry services are of an acceptable level. Cleaning and laundry services are monitored to ensure they continue to meet the needs of the residents. The existing buildings have a current building warrant of fitness which expires 22 June 2021 and approved fire evacuation plan. Essential emergency and security systems are in place. There is an approved fire evacuation plan for the old structure and emergency drills are conducted as required. Call bells allow residents to access help when needed. The certificate of public use (CPU) was issued and expires 30 January 2021. Certificate of compliance with inspection, maintenance and reporting procedures was issued.

Equipment and electrical checks are conducted. Fixtures, fittings, floor and wall surfaces are made of accepted materials for this environment. There is evidence of ongoing renovations and re-painting. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvering of mobility aids.

The new section is in the final stages of completion and is already furnished. The area is suitable for the needs of the hospital level of care resident. There are designated lounge and dining area that meet residents' relaxation, activity and dining needs. There are adequate toilet, bathing and hand washing facilities in the renovated area. The new area is suitably heated, cooled and ventilated.

The new area has call-bell system connected to mobile phones. There are appropriate processes and resources in place in the event of an emergency.

## 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 and one was using an enabler at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in restraint, challenging behaviours and de-escalation techniques through in-service training. Health care assistants working in the dementia unit have completed dementia related training.

## Infection prevention and control

The infection prevention and control management system are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented. Infection data is collated monthly, analysed and 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.

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| **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 | 16 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Services are planned to meet the needs of the residents. The service is in the final stages of converting an existing structure on the upper level of the hospital to make 10 more hospital level of care beds. The organisation is family owned and currently managed by the facility manager (FM) who reports to the Director. The mission statement and goals are displayed at the front entrance of the facility. The director, facility manager and clinical nurse manager meet monthly, and a current strategic and business plan were sighted. A transition plan was in place and clearly outlined time lines and any potential risks during the renovation period.  The strategic and business plans, which are reviewed yearly, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and long-term objectives and the associated operational plans. Monthly/quarterly reports to the director showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, occupancy, maintenance, quality management and financial performance.  Organisational performance is monitored in an ongoing manner. The facility manager is supported with day to day operations by the director and CNM.  Capella House currently provides a secure unit of 19 beds for residents with dementia who are able to mobilise independently, and 10 hospital level residents. There were 29 residents at the time of audit. There were four residents under the age of 65 years, one in hospital care and three in dementia care. Additional contracts are held with the district health board for the provision of respite and long-term support chronic health condition (LTSCHC). |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The director who is the owner acts as the facility manager when the FM is on leave, with support from the CNM. All members of the management team are suitably qualified to perform their respective roles. The CNM is responsible for any clinical issues that may arise. In interview conducted the FM reported that all necessary planning was put in place to ensure a smooth transition will take place. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes reference checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the providers agreement with the DHB. There are enough trained and competent RNs who maintain their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training.  Staff performance is monitored, and annual performance appraisals were sighted in all files reviewed. Competency assessment questionnaires are completed for medication management and restraint/challenging behaviour. All staff have received training to safely meet the needs of residents requiring hospital services.  The service has already recruited and employed an additional two health care assistants. There are no changes required to the education programme, as the service already covers relevant education for hospital level of care. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe care to residents, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there were adequate staff available to complete the work allocated to them. Observations and review of a four -week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is RN cover on duty every shift.  Staff on every shift are skilled and competent to deliver care safely to residents requiring hospital services. The FM has a proposed roster and transition plan to review the staffing allocation with the increase in hospital level of care. As the renovated/new hospital beds will be on the upper level, there will be an HCA allocated to the upper level at all times supported by the CNM, floating HCAs and registered nurses on duty. The proposed staffing allocations records the increased amount of care staff and nursing staff. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management system is implemented to ensure that residents receive medicines in a safe and timely manner. Three monthly medication reviews are completed by the GP as required. Discontinued medications are signed and dated by the GP. Allergies are clearly documented; photos are current and three-monthly reviews are completed. Medication charts are legibly written. The RN was observed administering medications safely and correctly. The medication and associated documentation are stored safely, and medication reconciliation is conducted by RN when resident is transferred back to service. The service uses pre-packaged packs which are checked by the RN on delivery.  There were no residents who self-administer medication and self-administration policies and procedures are in place if required. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted and all medications are stored appropriately.  An annual medication competency is completed for all staff administering medications and medication training records were sighted. Medication audits were completed, and all corrective actions rectified. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Meal services are prepared on site and served in dining rooms. The four weekly seasonal rotating menus have been reviewed by the registered dietitian. Diets are modified as required and the cooks confirmed awareness on dietary needs required by the residents. Alternative meal options 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 and 24-hourly as required. The family/whanau satisfaction surveys were sighted.  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.  The FM reported that the kitchen was adequately stocked and resourced to cater for the increased number of residents, adequate stock was sighted on the day of the audit. A proposed floor plan to modernise the kitchen was sighted and renovations were currently underway. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Activities are appropriate to the needs, age and culture of the residents. The diversional therapist (DT) develops an activity planner and daily/weekly activities are posted on the notice boards. In interview conducted the DT reported that 24 hr activity care plans are incorporated into the long- term care plans. Activity progress notes are completed daily. Over the course of the audit, residents were observed being actively involved in a variety of activities. In interview conducted the DT reported that, individualised activity plans are reviewed six monthly or when there is any significant change in participation and this is completed in consultation with the RNs.  The activities vary from animal therapy: visits to the workshop art gallery; housie; shopping; combined indoor bowls; art and craft; bingo; music; board games; van trips; exercises/walking; and church services. The diversional therapist reported that they have group activities and engage in one on one activities with some residents. Activities are modified to varying abilities and cognitive impairment. The residents’ activities participation log was sighted.  The DT’s hours have been increased from 35 to 40hrs a week and will be supported by HCAs, volunteers and students from the local college on attachments. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Policies and procedures are in place for handling waste and hazardous substances for the renovated area. 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. The renovated area has waste and laundry skips to allow the transporting of the waste to the current garbage and laundry storage areas.  Cleaning staff have received training in the handling of chemicals and hazardous waste. Chemicals are supplied and managed by an external provider. 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. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is publicly displayed expires 22 June 2021. A certificate of public use was issued by the council and expires 30 January 2021. Certificate of compliance with inspection, maintenance and reporting procedures was issued. Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. All the electrical and medical equipment in the refurbished area is newly purchased. The ongoing test and tag of electric equipment is included in the maintenance programme. The hot water temperatures in this new area are part of the monthly hot water checks.  The service is secured by electronic gates with security cameras and high fences. Residents can walk around freely throughout the facility and grounds. External areas are safely maintained and are appropriate to the resident groups and setting.  The service’s transition plan outlines the renovation/construction of additional 10 hospital beds to the service. The service has a comprehensive risk management plan to address potential issues during the renovation and construction. The final wiring and installation of the heating system was completed.  The physical environment minimises risk of harm, promotes safe mobility, aides independence and is appropriate to the needs of the residents at hospital level of care. The renovated area is on the upper level and there is a lift in place. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are two toilets and bathrooms in place. Bathrooms are fitted with handrails, non-slip flooring and call bells. The bathrooms have appropriate privacy, locking systems and signage. There are nine single rooms and one double room all completely furnished. Furnishing materials are waterproof. Hot water will be monitored routinely, where a variation occurs this is followed up. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Bedrooms provide nine single one double accommodation. Personal privacy is maintained. The hoist can fit through the bedroom doors. The rooms are already furnished with electric beds and wardrobes. There is room to store mobility aids and wheelchairs. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The renovated area provides safe, adequate, age appropriate areas for relaxation, activities and dining. There is a separate lounge and kitchenette area in the upper level. Staff, family/whanau and residents can access the existing external area by the lift and stairs. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All personal clothing and laundry are laundered on site by care staff and by family members if requested. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped, and the machinery is regularly serviced. Personal protective clothing is available including gloves, aprons and face masks. Adequate linen supplies were sighted. There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services.  Care staff are available daily to clean the many communal living areas, toilets and rooms. The cleaning schedule already includes the new area. There are processes in place to transport the cleaning trolley and laundry to and from the upper level. There will be no chemicals stored in the new area. The current cleaner’s cupboard containing chemicals will be used. Cleaner’s trolleys are well equipped and kept in locked areas when not in use. All chemicals have manufacturer labels. Cleaning staff were observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. The cleaning staff have completed chemical safety training. Documented material safety data sheets are available in work areas. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas were sighted and meet the requirements for the 39 residents. Water storage tank and a generator are available if required. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis.  The refurbished area has the same call bell/pager system as the secure dementia units and hospital area.  An improvement is required to ensure the new structure is assessed by the Fire and Emergency New Zealand to have an approved fire evacuation plan in place prior to occupancy. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by two heat pumps. Areas were warm and well ventilated throughout the audit. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme is reviewed annually and is incorporated into the review of the education programme. The programme is evaluated to assess the progress in achieving the goals and objectives. The infection control co-ordinator reports to the staff and facility manager on all aspects of infection prevention and control. Infection control is a standard agenda item at the monthly staff meetings.  There are processes in place to prevent staff and residents exposing others when they are unwell. Staff are encouraged not to come to work if they are unwell. There are processes in place to isolate infectious residents if this is required. There are notices on the doors to advise visitors not to visit if they are unwell. Sanitising hand gel is available at all entrances.  The roles and responsibility for the infection control coordinator is defined in their position description (sighted). Staff interviewed knew that they are required to report residents who are suspected of having infections to the RNs promptly. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff were able to identify the importance of hand hygiene and using standard precautions.  There is a Covid-19 information folder accessible to all staff to read. Staff and visitors Covid-19 screening forms were completed. Residents are closely monitored for any signs and symptoms. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Capella House has a commitment to provide quality services for residents in a safe environment and work to minimise the use of restraint. All staff receive education regarding restraint minimisation and management of challenging behaviours. Staff interviewed were clear regarding the difference between restraint and enabler use. The service currently has no residents using restraint but has one resident using an enabler. Environmental restraint is in place in form of coded locked doors where codes are displayed and family/whanau come and go as they please. A restraint register was sighted. |

# 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.

|  |  |  |  |  |
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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | Disaster and civil defence planning guides direct the facility in the preparation for disasters. These describe procedures to be followed in the event of a fire or other emergencies. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 22 June 2020. The contracted fire service conducts a monthly inspection of the fire equipment and evacuation routes. The orientation programme includes fire and evacuation.  A previously approved fire evacuation plan for old building was in place but the fire department was yet to visit and assess the new area. | The new area does not have an approved fire evacuation plan in place. | Ensure there is an approved fire evacuation plan that covers the new section.  Prior to occupancy 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 audit.

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| No data to display |

End of the report.