

Capella House Limited - Capella House

Introduction

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

The audit has been conducted by 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:	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: 18 April 2018 End date: 18 April 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	26

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Capella House provides rest home, hospital and secure dementia care services for up to 29 residents. There are two wings at the facility: a rest home /hospital wing and a dementia care wing, which is divided into two units one for males only and one mixed. On the day of the audit there were 26 residents, five of these were younger people under 65 years old (four in the dementia unit and one in the hospital).

There has been no change in management since the last audit. There has been a change of clinical nurse manager, but the role remains the same. Facility manager advised that notification made to the ministry of health as per section 31.

The service is family owned and operated and has a strong focus on activities that residents enjoyed pre-entry to service.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services Standards and the service's contract the district health board (DHB). 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.

The two previous areas requiring improvement have been addressed and no further areas of improvement have been identified during this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

Communication systems are appropriate to the needs of the residents. Sufficient information is made available. Interpreter's services can be accessed if required. Interviews with residents and family confirmed open communication opportunities with management and staff.

The complaints process is accessible. Records of complaints sampled confirmed appropriate and timely response. All complaints are followed up with a detailed letter and within the timeframe in policy. A register is maintained.

The facility manager (FM) stated there have been no complaints to external bodies since the last audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The organisation is governed by an owner operator who owns two other facilities. The running of the facility is undertaken by a facility manager (FM) who is supported by a clinical nurse manager (CNM).

Organisation performance is closely monitored.

The quality and risk management system is fully implemented. Quality data is used to improve the services. Policies and procedures are current. Adverse events are documented, investigated and closed in a timely manner.

Human resource process ensures suitably qualified staff are on site over 24-hour period. Competencies are maintained, there are sufficient staff on duty at any one time.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Care plans and assessments which are resident centred are developed and evaluated within the required time frames by the nursing team. The long-term care plans address the needs of the residents who wake up at night on a 24-hour period.

Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, family/whanau expressed satisfaction with the activities programme in place.

The service 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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There have been no changes to the facility since the last audit. There is a current BWOFF and approved fire evacuation plan.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint and three using enablers 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 course.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control surveillance programme is sufficient for the size and scope of the organisation and the infections control surveillance data is recorded and monitored.

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	16	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>There is a detailed complaints process set out in policy. The process provides details on how to access advocacy services or make a complaint to the Health and Disability Commission, the process includes the open disclosure policy, and this refers to right 10 of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>The complaints process is also outlined in detail in the resident's handbook and the admission agreement. A copy of the complaints process is on the notice board at the entrance to the facility, long with a framed copy of the Code in both English and Maori. The Code is also displayed in each dementia unit. A pamphlet holder contains advocacy pamphlets and complaint forms.</p> <p>A complaints register is kept, this provides evidence that complaints are dealt with in the time frames detailed in the policy and procedure. The facility manager (FM) is responsible for all complaints and responds to the complainant in writing. Any findings are part of feedback both at the staff meetings and the resident' meetings using information to form part of the quality process. Staff cover the complaints process in orientation and through internal training.</p> <p>In the previous area requiring improvement relating to lack of documentation regarding follow up from complaints, the process has been improved and all complaints are followed up with a detailed letter to the complainant explaining action taken. Review of register confirmed this.</p> <p>In interviews residents confirmed an awareness of the complaints process and stated they were able to raise concerns at the residents' meetings, via complaints forms or verbally to staff and management. Evidence of meeting</p>

		<p>minutes and complaints forms sampled showed this has occurred.</p> <p>In interviews family confirmed that they are comfortable to complain and that there is an open-door policy with management.</p> <p>Management report that there have been no investigations by the Health and Disability Commissioner (HDC), Ministry of Health, the Accident Compensation Commission (ACC) police or coroner since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy and procedures set out practice guidelines. Review of incidents and accident register demonstrated that open disclosure to residents and their families occurs within the time frames set in the policy. Staff files sampled confirmed that each resident has a family contact sheet and that each contact is documented. This occurs after an incident, accident, event or change in the resident's conditions. Family interviewed confirmed that they are contacted. Accident and investigation forms sampled had details of when family was contacted and their responses.</p> <p>Residents have monthly meetings and information is shared.</p> <p>Interpreter service is available, and documentation provides contact details. In interviews, staff reported that interpreter services have never been required. Residents and their families are informed of the interpreter service available in the resident's handbook, service agreement and by way of a poster on the notice board at the entrance to the facility.</p> <p>Staff interviewed confirmed that they are made aware of the interpreter's services at orientation and that they know how to access the service, if required.</p> <p>In interviews residents and family members stated that they feel comfortable discussing any matters with staff or management.</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>	FA	<p>The vision and mission statements are clearly identified in the organisations management manual and on the wall inside the front door of the facility. Residents and their families are made aware of the vision, philosophy and mission in the resident's handbook. These are also documented in the business plan date 2018 onwards.</p> <p>The FM oversees the day to day running of the home and is supported by the owner. The FM has been managing the home since it opened in 2015. The organisation chart clearly shows the line of management. FM position description further outlines the requirements of the role. There is evidence that the FM maintains training hours required and has professional expertise available from two other homes owned by the owner.</p> <p>At both service and organisational level, strategic planning is undertaken annually to ensure services offered meet the needs of the residents. The goals and objectives are reviewed at the managers' meetings held monthly.</p>

		<p>External advice and expertise is sought from NZ Aged Care Association</p> <p>There are clear delegations for on call and when the FM is not available. The FM is supported by a clinical nurse manager (CNM) who is on duty Monday to Friday and provides the day to day clinical oversight of the facility.</p> <p>The organisation is certified to provide dementia, hospital and rest home level services. There are 29 beds. The home has two wings one is dementia which is divided into two -a male only dementia unit with nine beds, one a mixed dementia unit with ten beds and the other a hospital / rest home wing with ten beds. The rest home /hospital beds are all swing beds. On the day of the audit there were 26 residents. 9 in the male only unit, 8 in the mix dementia unit and 9 in the hospital wing. In the male only dementia unit there were 4 residents who were under 65 and 1 resident in the hospital wing who was under 65, all under the LTS-CHC contract with the DHB. There were no rest home level clients at the time of the audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a documented risk management policy and a quality plan. The risk management plan identifies risks, responsibilities and controls documented. Quality and risk is integrated into the business plan and other organisational system including incident/accident process, complaints system, infections control, health and safety system, all are reviewed annually. Staff interviewed confirmed that they understand the quality system and that quality is covered in orientation and monthly staff meetings.</p> <p>The internal audit system provides evidence that continuous improvements are made. Service shortfalls are promptly identified and monitored until required threshold is met. (corrective action documentation sighted). Minutes from the staff meetings sampled show that reporting of clinical indicators and quality and risk issues occur. The data is analysed and compared to previous internal audit data. Trends are reported to the Quality Review meetings held quarterly. Informal management communication is frequent through email and phone calls.</p> <p>The policies and procedures are developed in line with best practice and legislation. All documentation is reviewed at least two yearly with most being reviewed annually. The document control process is clear and integrated into the quality system. Evidence of updating of documents viewed, staff sign when they have read a new document and obsolete documents are removed from circulation.</p> <p>Key components of service delivery are linked to the quality system and are standing agenda items at the monthly meetings.</p> <p>In interviews staff, family and residents confirmed that they are comfortable raising any issues, including newly identified actual or potential hazards with management and that issues are addressed.</p>
<p>Standard 1.2.4: Adverse Event</p>	FA	<p>There is a process for reporting and managing adverse events. Staff record adverse, unplanned or untoward events on incident/accident form. The FM collects further information if required and analyses the data, this data is reported</p>

<p>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>at the monthly staff meetings and compared to previous two months data. Information is used to feed into the quality system and improvements made. Management are aware of statutory requirements for reporting.</p> <p>Accident /incident registered was sampled. This confirmed that events have been well managed, families informed and closed off in a timely manner.</p> <p>Staff interviewed confirmed their understanding of the process and the need to report.</p> <p>Residents and families confirmed in interviews that the process was understood and easy to use.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource (HR) policies and procedures are in place. HR processes support good employment practice. There is a defined recruitment process which includes validation of professional qualifications and police checking. The FM is responsible for employment. Detailed position descriptions and job lists are out lined for each role.</p> <p>All staff receive orientation on employment, this includes all essential components of service delivery including emergency management.</p> <p>In-service training programme includes all mandatory education required. Staff records sampled confirmed education requirements have been met. The organisation requires a broad range of competencies to be completed this includes but not limited to: dementia training: managing challenging behaviour; medication and first aid. The in-service is planned yearly and incorporates information gathered from the previous year's quality data. Annual training plan for 2017 viewed and all 24 training sessions were delivered.2018 training plan viewed, and training is being delivered as per the plan. Annual practicing certificates for the RN's were sighted. InterRAI is managed by a senior manager who works across the three facilities. The CNM also has completed the InterRAI training. There is an electronic system for monitoring training attendance. All staff working in the dementia units have completed their dementia care qualification through career force or are working towards it. The CNM is an assessor. Files sampled confirmed dementia training is completed.</p> <p>Staff performance is monitored, and this includes annual performance appraisals.</p> <p>Staff records sampled included recruitment, orientation, training, competencies and appraisal records.</p> <p>In interviews staff confirmed completion of orientation and attendance at required training.</p> <p>The residents, families and GP interviewed all reported satisfaction with the knowledge and skills of the staff.</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>	FA	<p>There is a documented process which defines staffing levels. This meets the requirements outlined in the organisations contact with the Auckland District Health Board (ADHB). There is a registered nurse (RN) on every shift. The FM is on call 24/7 and if the RN is not available then the CNM is on call or one of the senior manager from one of the other facilities owned by the owner. There is always a staff member in each wing. There are dedicated activities staff six days a week and kitchen staff seven days a week.</p> <p>Roster sampled confirmed that there is adequate staff numbers for each shift. On the morning and afternoon shift there are 3 health care assistant (HCA), 1 RN and 1 floating HCA and on night shift there is one RN and one HCA. When the home is fully occupied then there are two HCA's and one RN on night duty. Rosters sampled (eight weeks) showed that in the event of sickness or absences staff replacement occurs.</p> <p>In the male dementia unit, the FM endeavours to have a male staff member on duty, this occurs a majority of the time.</p> <p>Observation during audit confirmed that residents' needs were met in a timely manner.</p> <p>Staff interviewed confirmed that they had enough time to complete their tasks.</p> <p>Family interviewed confirmed that staffing was adequate to meet the needs of the residents.</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>	FA	<p>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.</p> <p>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.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. Medication audit was completed and all corrective actions rectified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	FA	<p>Meal services are prepared on site and served in the allocated dining rooms. The service employs three cooks who work from Monday to Sunday. The menu has been reviewed by a registered dietitian to confirm it is appropriate to</p>

<p>And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>the nutritional needs of the residents. Diets are modified as required and the cook confirmed awareness of dietary needs required by the service. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made.</p> <p>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. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers. Records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is completed and all services comply with current legislation and guidelines. The service awaits to be audited by the external provider in order to meet the new required food safety standards. The residents and family interviewed acknowledged satisfaction with the food service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in short term care plans and long-term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed and the staff confirmed they have access to the supplies and products they needed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>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 board. Residents' files have a documented activity plan that reflects the resident's preferred activities of choice. 24 hr activity care plan is 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. Family/whanau interviewed expressed satisfaction with the activities in place. 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.</p> <p>The activities vary from animal therapy: visits to the workshop art gallery house; 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 service competed in the Invacare Small Operator Industry Award category and won a trophy and certificate from New Zealand Aged Care Association. Cappella house's ultimate goal has been to provide an environment where residents and their families feel most at home, independent and not as they are in a locked or secure institution.</p>

		They achieved the ultimate goal as confirmed by residents and family/whanau interviewed. Residents are engaged in other homely chores such as vacuuming; setting tables; collecting chicken eggs; folding washing; doing dishes and posting the mail. The activities are conducted with oversight from the DT.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' long-term care plans and activity plans are evaluated in a comprehensive and timely manner. Reviews are fully documented and include current residents' status, any changes and achievements towards goals. Family/whanau, staff and residents' input is sought in all aspects of care and are reviewed/evaluated. Short term care plans are developed as per rising need. All care plans reviewed are updated and reviewed every six months or as required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There have been no changes to the facility since the last audit. There is a current building warranty of fitness and approved fire evacuation plan.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a defined infection prevention and control system. The surveillance programme is appropriate to the size and scope of the organisation. Data on infections is recorded, monitored and measured. Monthly comparisons are maintained. Infection control reports are a standing agenda item for staff meetings. Data is used to implement actions to reduce infections. Records sampled confirmed that timely and appropriate actions are conducted. There are processes in place for managing outbreaks and appropriate reporting.
Standard 2.1.1:	FA	Capella House has a commitment to provide quality services for residents in a safe environment and work to

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>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 three residents using enablers. 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.</p>
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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.

No data to display

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

End of the report.