Melodie Enterprises Ltd - Sheaffs Resthome

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 HealthShare 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:	Melodie Enterprises Ltd
Premises audited:	Sheaffs Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 September 2019 End date: 24 September 2019

Proposed changes to current services (if any): Proposed change of ownership

Total beds occupied across all premises included in the audit on the first day of the audit: 27

Executive summary of the audit

Introduction

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

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

General overview of the audit

Sheaffs Rest Home, provides rest home level care for up to a maximum of 29 residents. Short stay /respite and can also be provided subject to bed availability. The rest home business is for sale with the prospective owners/directors intending to take ownership of the business on the 1st November 2019. A full certification audit was conducted in June 2019. There have been no changes in the organisation or facility since the June certification audit.

This provisional audit was conducted against a subset of the Health and Disability Services Standards and the service's contract with District Health Board (DHB). The audit process included interviews with the prospective owners/directors and a review of related records. Previously identified areas requiring improvement resulting from the June 2019 certification audit were also reviewed. The reduced audit scope was approved by the Ministry of Health (MOH).

There was sufficient evidence that the prospective owners/directors are prepared for potential ownership with no additional requirements identified. Two of the previously identified areas requiring improvement are in progress, with the remaining four areas sufficiently addressed.

Consumer rights

The prospective providers are well versed in their obligations under consumer rights legislation.

Organisational management

The prospective owners/directors have a defined organisational structure, with roles, responsibilities, accountabilities and authorities fully considered. Both prospective owners/directors have previous experience in the health sector, business ownership and management. The required business, risk and transition plans are documented. Plans for day to day management will ensure that a suitably qualified person is onsite, or on call, at all times with a pre-determined lead in time. The current quality and risk management programme and staffing regime will remain the same.

Continuum of service delivery

Continuum of service delivery was not included in the scope of the audit, other than to follow up on previously identified areas requiring improvement. Both prospective owners/directors have a clinical background and are aware of their requirements and responsibilities regarding service delivery.

Safe and appropriate environment

There is no intention to make any changes to the facility or grounds. The current environment meets all requirements.

Restraint minimisation and safe practice

The prospective owners/directors are aware of their responsibilities regarding restraint minimisation. There was one restraint in use at the time of the audit.

Infection prevention and control

The infection prevention and control programme was not included in the scope of the audit.

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	12	0	2	0	0	0
Criteria	0	30	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The June 2019 certification audit confirmed compliance with this standard. Both prospective owners/directors are registered health professionals who maintain their professional practice as required under the Health Practitioners Competency Act. One of the prospective directors is the local New Zealand Nursing Organisation (NZNO) delegate. The other is a general practitioner. In interview, both demonstrated an understanding of consumer rights legislation and how this is practiced in every day interactions with consumers of health services.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The proposed purchasing company is Melodie Enterprises Limited, which will continue trading as Sheaffs Rest Home. Melodie Enterprises was registered as a company in August 2019. The certificate of incorporation was sighted. Melodie Enterprises is owned and operated by the two directors. Both directors have previous experience in owning/managing privately companies. One of the directors is Sheaffs current general practitioner (GP) and has been providing GP services to Sheaffs for the past 12 years. This director is familiar with the rest home and all the residents. The other director works with the GP in general practice and is an

		experience registered nurse. This director is also familiar with the majority of the residents. Both directors are equal shareholders in the company. The shareholder's agreement defines high level responsibilities within the organisation. There is a proposed organisational structure which includes clearly defined roles for facility management and clinical management (refer standard 1.2.2 for further information). The prospective providers' vision is to provide wholistic services whilst maintaining close links to the community. A business plan was developed in July 2019. This describes the organisations value proposition, target market, sales and marketing, milestones with defined targets, the team and funding streams. The offer to purchase the business goes unconditional on the 11th October 2019, with the proposed ownership changing hands on the 1st November 2019. A full handover has been agreed and is documented in the sales and purchase agreement. This includes six weeks of ongoing support from the current owner/facility manager following the purchase. The rest home holds contracts with the Bay of Plenty DHB, for rest home level care, respite and a day programme but this is seldom used. Sheaffs Rest Home provides rest home level care for up to 29 residents. On the day of the audit, there were 27 residents. All but one resident, who is funded by ACC, were under the aged residential care contract. There is a boarder living next door to the home who is provided a main meal but doesn't access any other services. The prospective owners stated there will be no changes to the current services or contracts.
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 directors will share governance responsibilities and will both be on site each week, and available on call. One of the directors will be responsible for facility management and the other clinical management, however both are suitably qualified to cover for each other during a temporary absence. The directors are supported by an external accountant for financial advice, the assistant manager and the registered nurse. The registered nurse and assistant manager are both part time employees, covering three days each per week. The assistant manager has been with the organisation since May 2019 and is concentrating mainly on ensuring ongoing implementation of the quality and risk management system. The registered nurse has been with the organisation since November 2018 and is trained in the use of interRAI. One of the directors is also scheduled to completed the interRAI training to ensure there is

		sufficient resource allocated (refer standard 1.3.3 for additional information).
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The June 2019 certification audit confirmed compliance to this standard. The prospective owners intend to continue with the same quality and risk management system which is currently being implemented with the support of the assistant manager. This includes the current business plan, policies and procedures, the collection of quality related data and continuation of the internal audit programme. The prospective owners are familiar with their contract/compliance requirements. The prospective owners have considered current risks to the organisation and risks regarding ownership of the business. A full due diligence was completed with a lawyer, a review of compliance requirements was conducted and a building inspection was completed. Market research was investigated as was the sustainability of staffing resources in the community. The prospective owners will be leasing the building from the current owners, with first right to purchase in the future.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The June 2019 certification audit confirmed compliance to this standard. There have been no serious events since the last audit. It was reported that there are no events currently being investigated by external agencies. For example, Work Safe, the DHB or Ministry of Health. There is a current health and safety programme. The Ministry of Health (HealthCERT) and the funder have been informed regarding the sale of the rest home. In interview, the prospective providers were familiar with their reporting requirements under the Health Practitioners Competency Act and other essential notification requirements which are defined within the current quality system.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The June 2019 certification audit confirmed compliance to this standard. There is no intention to change the roster or staffing by the prospective owners. The enrolled nurse included in the rosters during the last audit has since retired, however both directors are clinical and able to provide additional clinical expertise and resource. The change in ownership has been discussed with staff all of whom confirmed they will be staying with the organisation.

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 remains the same. The medication management system continues to ensure that residents receive medicines in a secure and timely manner. An electronic management system is used in administration, reviewing, and e-prescribing. All staff who administer medicines were assessed as competent. There are no residents who self-administer medications at the service. Self-administration policy is in place for use when required. The previously identified areas requiring improvement have been addressed. A six-monthly reconciliation of controlled drugs was completed following the last audit. There were three residents being prescribed controlled drugs at the time of the audit. Entries on the electronic system confirmed that staff have included the effectiveness of 'as required' medication.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	The previous audit identified compliance to this standard with the exception of meeting timeframes for the completion of interRAI assessments. This corrective action is currently in progress. The RN utilises standardised risk assessment tools on admission.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The June 2019 certification audit confirmed compliance to this standard. The prospective owners stated there are no changes planned for the environment.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The June 2019 certification audit confirmed compliance to this standard. At the time of this audit there was one resident who had been approved to have a bed rail in place during the night for safety purposes, however this was seldom required. There were also two approved enablers, both being utilised by the same resident. These included the use of a lap belt whilst the resident was in a 'fall out' chair. One of the prospective providers, who is also the current GP, is well versed in restraint processes and has been actively involved in the assessment, approval and review of restraints.

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	There is evidence that the required assessment and approval process has been implemented for the use of restraint. This addresses the previously identified area requiring improvement. The GP confirmed involvement during the assessment and approval process. The restraint, enabler pre assessment form includes all the requirements of this standard and was fully documented.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The previously identified area of improvement regarding the evaluation of restraint has been addressed. A review of the use of bed rails for the one resident using them has been discussed, documented, monitored and evaluated. The review includes the requirements of this standard. The restraint register was current. The GP interviewed confirmed an understanding of the restraint review process.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The annual review of restraint was completed in August 2019. This includes the full requirements of this standard with records maintained. This addresses the previously identified area requiring improvement.

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)
Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	PA Low	Initial admission assessments are completed in a timely manner and resident care plans are completed as per policy within three weeks of admission along with interRAI assessments. The RN develops residents’ care plans and care plans were reviewed and evaluated every six months. Short term care plans were completed in a timely manner to reflect any changing residents’ needs. Initial visits by the GP occur within five days of admission as per policy. Three monthly reviews are completed by the GP. Care plans were not being evaluated in conjunction with interRAI assessments tools. There is evidence of progress regarding this area of improvement and the risk level has been reduced to low. The number of outstanding interRAI assessments has reduced to five with a target date for having these fully completed prior to the change in ownership. One of the prospective providers intends to complete the	Not all care plans were reviewed or evaluated in conjunction with interRAI assessments.	Provide evidence that care plans are evaluated or reviewed in conjunction with interRAI assessments 90 days

		interRAI training to ensure that these timeframes can be maintained in the future.		
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Initial assessments are completed within the required time frame on admission. Assessments and care plans include input from the family/whanau and other health team members as appropriate. There is evidence of improvement regarding the completion of interRAI assessments on admission and the risk level has been reduced to low, however this is yet to be fully completed.	Complete interRAI assessments as per contractual obligations.	Provide evidence that outcomes from interRAI assessments are documented in care plans 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.