Graceful Home No.2 Limited - Shelly Beach Dementia

Introduction

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

The audit has been conducted by 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:	Graceful Home No.2 Limited	
Premises audited:	Shelly Beach Dementia	
Services audited:	Dementia care	
Dates of audit:	Start date: 1 December 2020	End date: 2 December 2020

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: 10

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

Graceful Home No.2 Limited - Shelly Beach Dementia provides dementia level care for up to 13 residents with an occupancy of 10 residents on the day of the audit.

This certification audit was conducted against the relevant Health and Disability Standard and the contract with the District Health Board. The audit process included an interview with the owner/director, review of policies and procedures, review of resident and staff files, observations, a sample of quality related records and interviews with family, management, and staff. The general practitioner was not available to be interviewed.

Improvements are required regarding medication management, staffing and meal services.

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.

Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged.

The complaints process meets consumer rights legislation.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisation is governed by the owner/director who set the strategic vision and monitors organisational performance. There is a documented quality and risk management system. The required policies and procedures are documented and implemented. Quality activities are defined. The internal audit programme is implemented, with improvements made where required. The health and safety system meets current requirements.

There is a process for the recruitment, induction, education and performance monitoring of staff. The annual education programme is being implemented. There are a sufficient number of staff, and management, on site each day. Residents' information is kept securely with all entries legible and designated.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Residents are assessed prior to entry to the service to establish the level of care. The clinical nurse manager (CNM) is responsible for the following processes: assessment, planning, provision, evaluation and exit from the service. InterRAI assessments and care plans are completed in a timely manner.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Twenty-four-hour activity plans and diversional care plans are in place. There is a medicine management system in place. The general practitioner (GP) is responsible for three monthly medication reviews. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents' nutritional needs. Specific dietary likes and dislikes are accommodated. A food control plan was in place. Nutritional snacks are available for residents 24 hours.

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.

The facility provides a safe, secure and appropriate environment. There is a current building warrant of fitness and emergency evacuation plan. Maintenance is completed as required. All equipment, including medical and electrical, is checked as required. All staff receive training in the management of emergencies, with adequate supplies and resource available.

Each resident has a private bedroom. There is sufficient space available for the residents to enjoy communal or private areas/activities. Residents are free to wander outside to the secure gardens as they wish. All areas throughout the facility are well ventilated and can be heated when required. Cleaning and laundry processes are appropriate to the service and are monitored. Hazardous waste and substances are securely stored.

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.

The organisation has policies and procedures that support the minimisation of restraint. There were no residents using restraints or enablers on the day of the audit. Staff education on restraints, enablers and the management of challenging behaviour is provided. The facility and gardens are secure at all time, with access by keypad for staff and visitors.

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.

The 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 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 and is carried out as specified in the infection control programme.

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	42	0	0	3	0	0
Criteria	0	89	0	0	4	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Shelly Beach Dementia has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training as verified in the training records. The Code is displayed around the facility.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled showed that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by the activated enduring power of attorney (EPOA) and the general practitioner makes a clinically based decision on resuscitation authorisation. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members were aware of the advocacy service, how to access this and their right to have support persons. The CNM and staff provided examples of the involvement of advocacy services in relation to residents' care.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints management process meets the requirements of consumer rights legislation. There is a complaint register however, there have been no recorded formal complaints since 2016. There has been one verbal concern expressed in 2020 which has been followed up to the satisfaction of the person who voiced the concern. The facility manager reported that there have been no external complaints to the Health and Disability Commissioner, the district health board or from other external agencies. Family members interviewed confirmed that they have been advised of the complaints process on entry. An outline of the complaint's procedure is also included in the resident agreement. All family members interviewed reported that they would not hesitate to talk with the facility manager if they had a concern.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information about the consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process. The information brochure outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the 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 residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with the residents able to come and go within the building and around the secure grounds as they please. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The CNM reported that any allegations of neglect, if reported, would be taken seriously and immediately followed up. There are no documented incidents of abuse or neglect in the records sampled. Family members expressed no concerns regarding abuse, neglect or culturally unsafe practice.
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	Assessments and care plans document any cultural/spiritual needs. Special consideration to cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. The cultural needs of two residents who identify as Maori had been taken into account. The owner/director is committed to embedding tikanga into everyday practice. This includes the use of Te Whare Tapa Wha as a model of practice and reference to ministry of health strategies for ensuring equity and reducing barriers. Policies and procedures regarding the recognition of Maori values and beliefs are documented and currently being reviewed by the owner/director.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. All staff sign a code of conduct statement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.

		The CNM stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Shelly Beach Dementia is a registered subscriber to the ACE Dementia Programme supporting the older persons. The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) was not available to comment on the promptness and appropriateness of medical intervention when medical requests are sought. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Staff have either completed or are enrolled with the required dementia training. The organisation supports nursing student placements. There were two nursing students on placement from the local university during the audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health and medical information is collected to facilitate the effective care of residents. Staff know how to access interpreter services if required. Staff can provide interpretation as and when needed; the use of family members and communication cards when required is encouraged.
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 organisation is governed by the sole director who is supported by a business partner who provides financial support, a personal assistant, the facility manager (FM) and the clinical nurse manager (CNM). The owner/director owns two other rest homes and has been working in the aged care sector since 2010. The owner/director is on site weekly to catch up with the team. Monthly management meeting minutes are documented and provide evidence that the owner/director is monitoring organisational performance. The owner/director described the business plan, mission and vision of the organisation, including the intent to continually embed tikanga into the organisation and provide a person/family-centred approach to services. The organisation remains a current member of Care Association New Zealand (CANZ) which provides updates on trends within the aged care

		sector. The owner/director owns the business but does not own the building. Shelley Beach Dementia can provide care for up to 13 residents requiring rest home - dementia level of care. There were ten residents at the time of the audit. Day care respite services are also provided. There were no respite residents on the days of the audit.
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 FM was employed in July 2020, is onsite for 40 hours per week, and has a background in nursing overseas, leadership and health management and more recently specialising in dementia care. The FM's curriculum vitae and training records confirmed the required skills, experience and education hours. Recent education has included dementia and delirium, Alzheimer's, leadership and management and COVID-19 preparedness. The position description includes responsibilities, accountabilities and authorities. The FM is supported by the CNM. The CNM was employed in September 2020 and is on site Monday to Friday every second week and available on call in-between. The CNM is a registered nurse with a current practicing certificate who has experience in the aged care sector. The CNM's curriculum vitae and training records confirmed the required skills, experience and education including attendance at district health board (DHB) education days specific to aged care. The CNM is also supported by the DHB gerontology nurse who visits the service on a regular basis. Records of these meetings are maintained. Succession planning is in place in the event of a temporary absence of the FM or the CNM. There is an experienced team leader who can perform the role of the facility manager and the nurse from one of the other facilities can cover any absence of the CNM. The required notifications were made to the ministry of health (MOH) regarding the appointments of both the FM and CNM.
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	Policies and procedures are purchased from an external consultant. These are current and implemented. Policies are available to staff. Old documents are archived. The FM is responsible for document control. The CNM is responsible for the content of clinical procedures. The quality and risk management plan includes all quality monitoring activities, risk identification and mitigation strategies. Staff meeting minutes confirmed discussions regarding day-to-day business, staffing, resident care needs, maintenance, health and safety, adverse events, audits and corrective actions. Infection control surveillance data is also collated and analysed. Quality

		and risk management is included in staff orientation. The FM is responsible for implementing an internal audit programme. Internal audits completed recently included kitchen, laundry, resident care, challenging behaviour management, infection prevention and control, handwashing, privacy information, cleaning and the admission procedure. Corrective actions are developed for any identified short fall. For example, additional training on challenging behaviours was provided following an internal audit. Family feedback is obtained and documented on concerns/compliments forms. Records sampled confirmed satisfaction from family members regarding the care of the residents, quality of staff and the environment. The owner/director identified risks to the organisation and actions to address them. Occupancy is currently identified as the highest a risk for this rest home and there are strategies in place to address and monitor this. The FM attends cluster meetings for all providers in the area. These include discussions regarding trends and risks in the sector.
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	Incident and accident prevention, management and reporting procedures are implemented. Records of adverse events were tracked to confirm that the required processes are being followed. There was evidence that emergency actions were implemented and the required clinical observations documented. The required notifications, including notifications to the CNM and family members were evident. Investigation and monitoring of the adverse event process is the responsibility of the FM. Events are collated monthly, with an analysis and a comparison with the last year. There is early evidence that the corrective actions implemented following a type of event is improving the outcomes for the residents. For example, additional staff training on falls prevention has resulted in a reduction in the number of falls for November 2020. The required notifications to the Ministry of Health regarding the employment of the FM and CNM were made.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the	FA	There is a total of 12 staff, including management. There is one team leader, one diversional therapist, one cook and one cleaner. Of the seven (7) health care assistants, four have the level 4 dementia training and the other three (3) are currently enrolled. Policies and procedures in relation to human resource management are implemented. There is a process for recruitment, orientation and training. Recruitment is the responsibility of the FM. Staff files sampled confirmed that the required reference checks, police vetting and validation of

requirements of legislation.		qualifications is completed. The CNM has the required interRAI competency. All new staff receive an orientation to the facility and to their respective role. Health care assistants confirmed implementation of the orientation process. A record of orientation is retained on staff files. Records of completed orientation include the essential components of service delivery, including emergency procedures and health and safety. Staff performance is monitored in an ongoing manner and performance appraisals were sighted in staff records sampled. An annual training plan is developed and implemented. Topics provided in 2020 have included falls, medication competency, emergency training, nutrition and hydration, pressure injuries, challenging behaviour and infection prevention and control. Records of attendance are maintained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	The documented rationale for determining service provider levels and skill mix is based on occupancy ratios. The owner/director approves the rosters. The FM is onsite Monday to Friday, business hours. Both the FM and CNM are available on call including overnight and weekends. There is one staff member rostered on each day shift, with an additional short shift to cover busy periods of the day. The FM has developed a list of staff allocations to establish responsibilities and accountabilities for each shift. This includes regular breaks for health and safety purposes. An improvement is required regarding staffing levels during the night.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident records are held electronically and paper based. Staff have individual passwords to the resident records data base such as the medication management system and CNM on the interRAI assessment tool. The visiting GP and allied health providers also have access to the system which supports integration of resident records. Some resident records are maintained in hard copy. This includes the admission agreement, consent agreements and the current care plan. All hard copies are kept securely in the locked cupboards. Hard copy archived records are stored safely and securely on site. There is an effective system for retrieving both hard copy and electronically stored resident records. All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift. The CNM reviews all progress notes weekly, or as required.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to service policy includes all the required aspects on the management of enquiries and entry. Shelly Beach Dementia brochure and web site contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a documented process for the management of transfers and discharges. A standard transfer form notification 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.
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.	PA Moderate	The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The CNM was observed administering medications safely and correctly. Medications were stored in a safe and secure way in the trolley and locked storeroom. Medication reconciliation is conducted by the CNM when the resident is transferred back to service from hospital or any external appointments. Medication competencies were completed annually for all staff administering medication. There were no residents self-administering medications. There were no resident's prescribed controlled medication during the days of the audit. Weekly and six-monthly stock takes were conducted, and this was confirmed on previous entries. An improvement is required in relation to documenting outcomes for as required (PRN) and three-monthly medication reviews.
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	PA Moderate	There is an approved food plan for the service which expires 21 July 2021. Meal services are prepared on site and served in the allocated dining room. 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. The

delivery.		family members acknowledged satisfaction with the food service. An improvement is required regarding menu reviews and expired food stuffs.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The CNM reported that all consumers who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents have their level of care identified through needs assessment by NASC agency. Initial assessments were completed within the required time frame on admission while resident care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. Additional assessments were completed according to the need e.g. behavioural, nutritional, continence, and skin and pressure assessments. The CNM utilise standardised risk assessment tools on admission. In interviews conducted family/whanau expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. Family/whanau confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, district nurses, dietitian and GP.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their	FA	Interventions were adequate to address identified needs in the care plans. The individual behaviour management plans specified prevention-based strategies for minimising episodes of challenging behaviours and described how the residents' behaviour was best managed over a 24-hour period. Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the CNM. Health care assistants confirmed that care

assessed needs and desired outcomes.		was provided as outlined in the care plan. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs.
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	Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the DT from Thursday to Sunday and the health care assistants from Monday and Wednesday. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. A life story book is completed for each resident within two weeks of admission in consultation with the family. The DT formulates activities in consultation with the FM, CNM, family/whanau and basing on the events of the day. The activities are varied and appropriate for people living with dementia. Twenty-four-hour activity plans and DT care plans reflect residents' preferred activities of choice and are evaluated every six months or as necessary. Activity progress notes and activity attendance checklists are completed daily. The residents were observed to be participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented on each shift by care staff in the progress notes. The CNM reads progress notes weekly, documents as necessary and countersigns entries. All noted changes by the health care assistants are reported to the CNM in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by the CNM in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And	FA	Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested,

External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		the GP and CNM sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the CNM, FM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.
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	There are documented policies and procedures for the management of waste and hazardous substances. These are documented in the cleaning/laundry policies, medication procedures and the infection prevention and control manual. Domestic rubbish is secure and removed as per council requirements. All staff receive education during orientation regarding the management of waste and hazardous substances. Chemicals are safety stored. A sharps container is available should it be needed. Continence products are double bagged and removed. Staff have access to the required personal protective equipment (PPE) and were observed using PPE appropriately. There have been no adverse events regarding the management of hazardous substances.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Maintenance is addressed in a routine and ongoing manner. Records of maintenance requests are maintained and confirmed that they are addressed. Generalised wear and tear of the building and floor surfaces is monitored and addressed. Internal corridors and exit ramps have safety rails. The current building warrant of fitness is displayed. A contracted company completes the certification of compliance through monthly inspections, maintenance and reporting procedures. Electrical equipment is tagged and medical devices are calibrated. Health and safety requirements are maintained, including hazard identification. Environmental health and safety is monitored through internal audits. There are easily accessible, and secure, outdoor areas with well-maintained gardens. Residents were sighted moving around safely both indoors and outdoors. All furniture and fittings are replaced as needed. Family members confirmed the environment is suitable to meet the needs of the residents and noted that a number of improvements to the facility have occurred.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There is an adequate number of toilets and shower facilities to meet the needs of the residents. Toilet and showering facilities are shared. Each bedroom has a hand basin. Hot water is routinely monitored and records confirmed that the temperature remains consistent and within

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.		recommendations. Wall linings in the wet areas are monitored for water tightness. A staff/visitor toilet is available. Hand sanitiser is available throughout the facility.
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	All rooms are currently single occupancy. Rooms have sufficient space to accommodate personal items, equipment and for the resident to move around safely. Rooms include adequate storage with a built-in wardrobe in each room. Family members interviewed confirmed satisfaction with the bedrooms rooms.
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 facility has a well-proportioned lounge and separate dining room. Communal areas are well furnished. Outdoors areas have raised gardens, sufficient seating and shade cloths. Private bedrooms can be used a quiet areas if needed.
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	There are documented processes for the management of cleaning and laundry. This includes daily task sheets for all cleaning and laundry duties. There are designated cleaning staff. The laundry has identified clean and dirty areas and a safe and sheltered area for drying. Laundry and cleaning products are provided by an external contractor and labelled. There are secure areas for all chemicals to be stored. Cleaning and laundry services are monitored through routine internal audits. Family members interviewed confirmed satisfaction with the cleaning and laundry service. On observation, the laundry was tidy and all areas throughout the facility appeared clean.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The approved fire evacuation plan was sighted. Trial evacuations are completed every six months as required. Records of fire drills sampled confirmed good staff attendance. Fire equipment is displayed and maintained. Emergency evacuation procedures are displayed throughout the building. There are smoke alarms in each area. The sprinkler system is routinely checked. There are sufficient supplies of emergency equipment. This includes the civil defence

		recommendations regarding appropriately stocked water, food, first aid supplies and a civil defence kit. Extra blankets are available and the BBQ can be used in the event of a power outage. The building has emergency lighting. All staff have a first aid training. Emergency procedures are included in staff orientation, revisited during regular staff meetings and consider the special needs of the residents. Call bells are located outside the resident's bedrooms, bathrooms and toilets. This has been deemed appropriate for this setting and family have been advised regarding methods to access staff in an emergency situation. Call bells have been checked by an electrician. There are security lights outside the building and security cameras inside. Staff conduct security checks each evening. The environment is secure with keypad entry.
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	The building is ventilated and heated appropriately. A combination of heating appliances are installed. All bedrooms have an external window of normal proportions. There is one resident who smokes. There is a place for smoking that is away from the other residents.
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	There is a documented infection prevention and control programme. The programme is reviewed annually. The review includes a review of the last year's annual infection control data, plus training, internal audits and policies and procedures. The review is completed by the FM and CNM and reported in the staff and management meetings. The FM and CNM share the role of the infection prevention and control coordinator (ICC) The position description is well defined. Exposure to infection is prevented in a number of ways. The organisation provides relevant training, there was adequate supplies of personal protective equipment (PPE) and hand sanitisers. Hand washing audits are completed, the required policies and procedures are documented, and staff are advised to not attend work if they are unwell. Flu vaccines are offered to all staff and residents. There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 was regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by MOH were documented. The service was audited by the local DHB to check its preparedness to the COVID-19 outbreak at the facility. Documented evidence relating to this was sighted and the required actions had been developed and implemented. The organisation now has a well-documented COVID-19 process.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The FM and CNM are responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at management and staff meetings. The ICCs have access to all relevant resident data to undertake surveillance, internal audits and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory and the GP.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Shelly Beach Dementia has documented policies and procedures in place that reflect current best practice. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff training on infection prevention and control are routinely provided during orientation and annual in-service education. In-service education is conducted by either the CNM or FM. The following training was provided in 2020: outbreak/pandemic policy and procedure training, hand washing procedure and infection prevention and control. Records of staff education are maintained.
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	The surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections. Infection control surveillance data confirmed that Shelly Beach Dementia has had a minimal number of infections, with one infection reported so far this year.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Shelly Beach Dementia has a commitment to provide quality services for residents in a safe environment and work to minimise the use of restraint. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. Restraint/enablers and the management of challenging behaviour is included in staff orientation and ongoing education. The service had no residents using a restraint or enabler at the time of the audit. The facility provides a safe and secure environment with residents able to wander into outdoor areas whenever they want to.

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 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	There is one staff member rostered on overnight. This staff member has the required dementia training and a first aid certificate. The CNM is available on call overnight if additional support is needed. It was reported that residents are settled during the night and there has been no need to request on-call support, however there is no additional second staff member on site on call as required.	Staffing requirements for the night shift do not meet contractual requirements.	Increase the availability of staff over the night shift. 30 days
Criterion 1.3.12.1 A medicines management system is implemented to manage	PA Moderate	The service uses an electronic management system for medication prescribing, dispensing, administration, review and reconciliation. Indications for use are noted on ‘as required’ medications, allergies are clearly indicated, and photos are current. Administration records are maintained, and drug incident forms are	Three monthly medication reviews were	Provide documented evidence of three-

the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		completed in the event of any drug errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the CNM when a resident is transferred back to service. The CNM checks medicines against the prescription. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. It was reported that the three-monthly medication reviews were being conducted by the GP, however the reviews were not being documented. Outcomes following the administration of PRN medication was not being consistently documented.	not being documented by the GP and not all outcomes of administered PRN medications were documented.	monthly medication reviews and evaluation of administered PRN medication 90 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Moderate	The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. There is a four-weekly rotating winter and summer meal in place. The menu has not been reviewed by the registered dietitian since July 2015 to confirm it is appropriate to the nutritional needs of the residents.	Menu has not been reviewed by the registered dietitian within the last two years.	Provide evidence that residents' menu has been reviewed by the registered dietitian. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and	PA Moderate	All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted. There was a large amount of frozen meat stored, some of which had extended its use by date.	Some meat in the freezer had past the use by date.	Ensure all meat that has passed its use by date is removed from the freezer and

guidelines.				is disposed of. 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.