

Agape Care Warkworth Limited - Bethany Hill Dementia Care

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 The DAA Group 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: Agape Care Warkworth Limited

Premises audited: Bethany Hill Dementia Care

Services audited: Dementia care

Dates of audit: Start date: 7 December 2020 End date: 8 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: 24

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

The service is owned by Agape Care Warkworth and trades as Bethany Hill Dementia Care providing secure dementia care for up to 30 residents. The service is managed by one of the owner/directors who is the facility manager/registered nurse. The facility manager is supported by two registered nurses. Families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with family, managers and a general practitioner (GP).

No areas were identified as requiring improvement. A continuous improvement rating was made in relation to the evaluation and significant improvement in the service's emergency plan, taking into consideration the staff obligations and the special needs of people with dementia in an emergency situation.

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.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

There is open communication between staff, residents and families or enduring power of attorney (EPOA). There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

The complaints management system is readily accessible and managed in compliance with the Code of Rights.

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.
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The business plan and strategic plans are reviewed annually. These plans outline the purpose, values, scope, direction and objectives of the organisation. The facility manager reports against the objectives at the quality meeting held monthly. Adequate information to monitor performance is reported including any emerging risks and/or issues.

The service is managed by one of the owner/directors who is the facility manager. The facility manager is a registered nurse with a current annual practising certificate. The facility manager works across two dementia care services, working two days a week at each site and a third day is used as needed to arrange admissions, talk with families or manage any arising issues. Quality and risk

management processes are established and maintained and improvements implemented whenever practicable. Adverse events are recorded and actions taken to prevent recurrence. An effective health and safety and hazard management system is in place.

The organisation has established human resources management processes and staffing is stable. Staff numbers and skill mix are suitable for the layout of the facility and for the residents accommodated.

Residents information was entered into records in a timely way and was appropriate to the service setting.

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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Access to Bethany Hill Dementia Care is appropriate and efficiently managed with relevant information provided to the potential resident's family.

Residents are assessed by the multidisciplinary team on admission, including a registered nurse and general practitioner. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Family members and enduring power of attorneys verified satisfaction with meals.

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 is a residential care facility divided into three wings all on one level. The building, fittings and furnishings are regularly maintained. Each resident has their own room, and a lounge and dining room is in each area of service delivery.

There are sound processes for management of waste, emergencies and security.

Cleaning and laundry processes are effective and meet regulatory requirements.

The outside area is secure and appropriate for residents with dementia to walk around safely and freely.

The temperature was comfortable throughout the facility. The facility has plenty of natural light.

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.

There was no restraint or enabler use at the time of the audit. The environment is restraint free due to the nature of this dementia care service. Staff are trained in de-escalation to manage any challenging behaviour as needed.

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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	45	0	0	0	0	0
Criteria	1	92	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Bethany Hill Dementia Care has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence and providing options. Personal cares were completed behind closed doors. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
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 provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Resuscitation treatment plans were completed for all residents in the files reviewed. Advance care plans were in place for some residents. All files reviewed evidenced appropriate documentation of enduring power of attorney requirements and activated EPOAs were sighted. Staff were observed to gain consent for day-to-day care.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Family are given a copy of the Code, which also includes information on the Advocacy Service during the admission process. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members spoken with were aware of the Advocacy Service, how to access this and the residents' right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The documented complaints process meets the requirements of the Code. Complaints information and forms were available. Review of sampled records indicated that the complaints process is implemented in practice.</p> <p>Family members interviewed were aware of their right to complain and the process by which they may do this. They confirmed that they would feel comfortable raising any issues with the manager and staff.</p> <p>The complaints register is maintained by the manager with the names, date, summary of complaint, actions taken and sign off when completed. The two complaints received since the last audit were addressed within the timeframes of the Code. There have been no complaints received from external agencies. The staff demonstrated knowledge of the complaint management process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The interviewed family members reported that the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) was part of the admission information provided and was discussed with staff on admission. The Code is displayed in all three areas together with information on advocacy services and how to make a complaint.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Families confirmed that residents received services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room or share a room.</p> <p>Residents are supported to maintain their independence where appropriate, for example, when attending to community activities and participation in activities of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Interviewed family have not witnessed or suspected any abuse.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs when required. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The facility has links with the local Maori cultural advisors. Whānau interviewed reported that staff acknowledge and respected resident's individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Family verified that they were consulted on residents' individual culture, values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed, for example, preferred cultural food. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	FA	<p>Residents and family members interviewed 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 registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they</p>

other exploitation.		would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, psycho-geriatrician, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Family members and EPOAs stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed through the local district health board (DHB), although staff reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed and the use of family members and hand gestures for those with communication difficulties.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The facility is owned by Agape Care Warkworth Limited and is trading as Bethany Hill Dementia Care. There are two owner/directors who own two dementia care services; Bethany Hill Dementia Care and another facility north of Auckland. Bethany Hill Dementia Care was purchased three years ago and one of the owner/directors is the facility manager covering the two sites, working two days a week at each site and the extra day per week wherever needed at the time to follow-up enquiries, new admissions and to talk with families. The facility manager (FM) interviewed is a registered nurse with a current annual practising certificate (APC) and has eleven years of experience working as a registered nurse. Two experienced registered nurses support the FM. The FM is a member of an aged care association and receives ongoing education and updates regarding management of aged care services. Professional development hours are maintained for both nursing and management. The registered nurses (one of whom was interviewed) report to the FM regularly on a daily basis.</p> <p>The organisation's vision, mission, values and objectives of the residential dementia care services are</p>

		<p>set annually and this was documented in the business plan 2019 to 2021 reviewed. Family/whanau interviewed reported satisfaction with the care and service delivery. This is also supported through the satisfaction survey results.</p> <p>The service provides rest home dementia level care for up to 30 residents. At the time of audit there were 24 residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Either of the two experienced registered nurses can cover the service in the absence of the facility manager as confirmed at interview and the job descriptions sampled. The facility manager reported confidence in both registered nurses' ability to take on the role as required.</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>The quality plan describes the quality and risk management system. The plan is reviewed on an annual basis and approved by the directors. The plan covers the key aspects of service delivery. Monitoring timeframes and target dates are identified. The quality objectives are also monitored through the internal auditing programme monthly. The facility manager and registered nurse demonstrated knowledge of the quality and risk management systems and reported that outcomes are discussed at meetings and reported back to staff at the staff meetings held one to two monthly as per the minutes of meetings reviewed. The service has completed several quality improvement projects related to the environment and wound care management.</p> <p>The policies are referenced to legislation best practice and reviewed on a two-yearly cycle or sooner if there are any changes to legislation. A contracted quality consultant is available and provides assistance with any changes required. The organisation has a documented risk management plan which identifies risks and management strategies. All potential and actual risks were reported and reviewed regularly since the previous audit. Clinical risks were discussed at the quality meeting and staff meetings as confirmed in meeting minutes sighted and confirmed by staff. There is now an up-to-date hazard register and the process for reporting hazards is understood by staff interviewed.</p> <p>Quality data collection and analysis is maintained, and evaluation of results shared with staff. Corrective actions and quality improvements were put into place where quality data indicated any shortfalls. Staff confirmed that all follow-up actions are discussed during handover and at the regular staff meetings. Data and information for all key components of the service inclusive of complaints, incidents and</p>

		<p>accidents, health and safety, hazards and infection prevention and control are collected, evaluated and trended.</p> <p>The risks, hazard and emergency response plan identified potential and actual hazards. The plan included what the hazard is, risk level, preventative actions and ways to minimise risk. If the risk is ongoing this is monitored through the hazard register and monitoring frequency is based on the level of risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is a documented policy for the management and recording of accidents and incidents. Management and staff interviews and records of adverse events relating to falls and challenging behaviour provided evidence that they are well documented. Communication with family members and the GP is appropriate and timely in these cases. Minutes of quality meetings provided evidence of discussion of incidents and actions taken.</p> <p>The facility manager and the senior registered nurse interviewed were aware of responsibility for reporting adverse events to external authorities. This includes the reporting of stage three and above pressure injuries. The service received a letter recently about a resident transferred to the DHB that has since been transferred to another facility. An investigation is currently underway, and all requested and required documentation has been forwarded to the DHB in a timely manner, in regard to an adverse event reported and being actioned by the DHB.</p> <p>There is a monthly analysis of any adverse events which includes a trend analysis. Where any shortfalls have been identified actions are implemented to make improvements to service delivery such as actions to reduce falls and skin tears. Falls are noted as being unwitnessed or witnessed and appropriate observations are performed as per the policy reviewed. The GP is notified and involved as necessary. The results are discussed at staff meetings. The staff demonstrated knowledge of when to complete incident/accident forms.</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>	FA	<p>Staff that require professional qualifications have them validated as part of the employment process annually. A copy of the current annual practising certificates was sighted for all staff and contractors who required them.</p> <p>Policies and procedures identify human resources management that reflected good employment practice and meet the requirements of legislation. Staff records showed that prior to employment references and police checks were completed. Job descriptions clearly described staff responsibilities and best practice standards.</p> <p>Staff had completed the required orientation programme with specific competencies for their roles. The</p>

		<p>staff records confirmed employment orientation, performance appraisals and ongoing education was implemented.</p> <p>The appointment of appropriate staff is undertaken to safely meet the needs of residents. There are 18 caregivers employed at Bethany Hill Dementia Care. Caregivers' have completed or are completing relevant New Zealand Qualification Authority (NZQA) aged care and dementia training. One caregiver has level 4, three level three and five are experienced in dementia care, completing training under the previous management. Three caregivers are currently training for level three and four. Four caregivers are newly employed and are enrolled to commence training in 2021, to meet the requirements of the provider's agreement with the DHB. One senior caregiver/supervisor is (a registered nurse) studying currently for a Masters in Nursing with no current APC). All staff except two caregivers have completed first aid training. The gerontology nurse specialist has provided training in 2020 and the planned 2020 programme objectives were met with on-line care training being available.</p> <p>The registered nurses also were involved and covered topics at the staff meetings held monthly. A record of attendance was maintained. The service has two RNs that are trained and assessed as competent to use the interRAI assessment tool.</p> <p>A senior caregiver acts as a leader/supervisor for the caregivers and is well received in this role by all care staff and this person reports to the registered nurses.</p> <p>Family/whanau members interviewed identified that the service is meeting residents' needs.</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>A documented policy details staffing levels and skill mix requirements, and this aligns with the obligations of the provider's contractual requirements for dementia care services. The level is higher than required due to the layout and design of the facility which has three separate areas within the one service. Additional staff hours are put in place as required (such as for a resident presenting with increased challenging behaviour) and the registered nurses can increase the levels as needed.</p> <p>There are three care staff on duty on morning and afternoon shifts and two caregivers at night. In addition, in the mornings, there is a registered nurse five to six days a week and the other registered nurse is employed 30 hours a week. The registered nurses completed the interRAI assessments and update the care plans as part of their daily work and complete the day to day running of the facility. The FM completes the management aspects of the service.</p> <p>Staff and family interviews and review of rosters indicated that there is adequate staffing for the number of residents, the level of care and the lay out of the facility. Staff interviewed confirmed that assistance is readily available if they need it. The registered nurses share the on-call after-hours and staff reported this system works effectively and that advice is always available if needed. One staff on each shift has a first aid certificate. There are sufficient, household support staff (cleaners/laundry) and activities staff to</p>

		meet the needs of the residents. The staff interviewed reported they can complete their work in the time allocated.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP, physiotherapy, podiatrists, nursing and other allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The admission enquiries and process to entry is managed by the facility manager (FM) and the RNs. Pre-entry assessment was completed by the local Needs Assessment and Service Coordination (NASC) Service for all residents in the files reviewed. Prospective residents and/or their families are encouraged to visit the facility prior to admission. The admission pack contained written information about the service and the admission process. The organisation seeks updated information from NASC and the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that was made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort provided as appropriate. The on-call RN support the caregivers after hours as required. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the family/whanau and the EPOA. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals were documented in the progress notes. An example reviewed of a resident recently transferred to the local acute care facility showed that appropriate documentation was completed. Family of the resident reported being kept well informed during the transfer of their relative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment</p>

		to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed.
<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>Bethany Hill Dementia Care has a current medication management policy that identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a paper-based system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Current medication administration competencies were sighted.</p> <p>A contracted pharmacy supplies medication to the facility in a pre-packaged format. The RN checks medications against the prescription and completes medication reconciliation when residents are received from acute services. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>There were no controlled drugs kept on site. There were no residents who self-administer medications. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>The medication charts reviewed included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by three cooks and is in line with recognised nutritional guidelines for older people. The kitchen staff have completed relevant food safety and handling training. The menu follows summer and winter patterns in a four weekly cycle and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The kitchen was clean and decanted food in the fridge was labelled and covered.</p>

		<p>A diet profile is completed for each resident on admission. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Drinks and snacks are always available in a 24-hour period for all residents. Special equipment, to meet resident's nutritional needs, is available. Meals are served in three dining rooms: one dining room in each of the three wings.</p> <p>Evidence of resident satisfaction with meals was verified by family members interviews and satisfaction surveys. On the days of the audit, residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The RN stated that prospective residents who do not meet the entry criteria, for example, those who need higher level of care or when there is no vacancy, are declined entry to the services and are referred to alternative service providers. Their family/whanau of choice are informed of the reason for the decline. The local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative when required. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and behaviour assessment, were used to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Families and EPOAs confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. Residents' individualised needs were evident in all areas of service provision. Hourly monitoring was completed for all residents and records were maintained. The GP verified that medical input is sought in a timely manner, and that medical orders are followed, and care is provided as prescribed. The caregivers confirmed that care was provided as outlined in the documentation. Appropriate equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs.</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>A social history assessment is completed on admission to ascertain residents' needs, interests, abilities and social requirements. Residents' participation in activities is monitored daily and records were maintained using a daily attendance record sheet. Individualised activities care plans were completed for all residents including a 24-hour care plan. Activities care plans were evaluated six-monthly as part of the formal six-monthly care plan review. Where there was a significant change in a resident's condition and attendance, the activities plan was reassessed and updated as required.</p> <p>The activities programme is provided by an activities coordinator with the support of an activities assistant. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Activities on the planner are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. Residents were participating in a variety of activities. The activities on the programmes included balloon games, walks, seated dancing, craft, gardening, music, bowls and volleyball.</p> <p>Family/whanau are involved in evaluating and improving the programme through satisfaction surveys and six-monthly residents' care evaluations. Family interviewed confirmed the programme was adequate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes by the caregivers. If any change is noted, it is reported to the RN. The RN reviews the progress notes and document weekly and more frequently as determined by residents' condition. This was verified in records reviewed.</p> <p>Care plans reviewed evidenced that formal evaluations occurred every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. Short-term care plans were completed for chest infections, urinary tract infections and weight loss. Unresolved problems were</p>

		added to long-term care plans. Family/whanau interviewed confirmed being involved in evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The service has a contracted GP, but the residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the mental health team. The family/whānau and EPOAs are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals were attended to promptly with the support of the RN, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are suitable documented guidelines in place for the management and storage of waste and hazardous substance that meet health and safety, infection prevention and control and local body requirements. Staff receive training in safe handling processes. Wall mounted chemicals were visible in the laundry. Personal protective resources are readily available such as gloves, masks, and aprons, and secure storage facilities are provided. Material safety data sheets were readily accessible.</p> <p>A waste management company is contracted.</p> <p>A quality improvement project has resulted in improved storage and reduced usage of chemicals in the facility.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The care facility is well maintained internally and externally. Internal areas are level and well lit. Handrails are installed in corridors and bathrooms. External areas have handrails and non-slip surfaces. External pathways are paved. Suitable external sheltered seating is available. Residents are able to walk freely throughout the three individual wings of the facility to the outside and back into the facility with no barriers in place.</p> <p>There is a maintenance programme in place that is monitored by the facility manager. A current building warrant of fitness was sighted with and expiry date of 22 February 2021.</p> <p>An equipment register is maintained by the facility manager and there are records of the required functional and calibration checks. All electrical appliances and equipment are tested and tagged annually by the owner/director who has completed the necessary qualifications to be competent to</p>

		undertake this role.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>The service has three separate wings; two with 11 bedrooms and one wing with eight rooms. All rooms have a hand basin. Four bedrooms in the facility have their own toilet. Showers and toilets with hand basins are in close proximity to all residents' rooms. There is a designated staff/visitor toilet with keypad access. Infection prevention and control measures are in place with flowing soap, hand towel dispenses and rubbish disposal bins in place. The families reported satisfaction with the facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents' bedrooms are single size and are furnished with bed, side table and chair. There is adequate space for mobility aids and personal furniture and other items. The family, one resident and staff reported satisfaction with the space in the rooms. Families are encouraged to personalise the rooms for their family member living in this residential care home.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are three lounge and dining areas, one in each wing. These rooms are freely accessible to the residents and are decorated with wall features providing a homely environment. The families interviewed reported satisfaction with the recreational and dining facilities. There are three additional areas available with seating for residents to enjoy located around the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is</p>	FA	<p>A well-equipped separate area is provided for residents' personal laundry. All laundry is done on site by staff who are trained in this role. Washing and drying machines are regularly checked and serviced. Temperatures are monitored and maintained to meet safe hygiene requirements. The two designated laundry persons have received training and documented material data sheets are available. Audits were completed as per the audit schedule reviewed. In addition, laundry & cleaning schedules displayed on the wall in the laundry are completed daily. There are baskets available for each resident's clean clothes and these are delivered to their rooms and put away appropriately.</p>

being provided.		Cleaning is undertaken by cleaning staff. Cleaning guidelines are provided. There is suitable, safe storage for cleaning equipment and supplies. Cleaning schedules are maintained for daily and periodic cleaning. Cleaning audits are done monthly. Inspection on site confirmed that a high standard of cleanliness is maintained throughout the facility. Family survey results indicate general satisfaction with the standard of cleanliness maintained in the facility. A quality improvement project that introduced a new method of cloths that are colour coded for surfaces, furniture, floor etc. has resulted in more effective and efficient cleaning. A specific benchtop cleaning machine is located in the laundry for washing the cloths and other resources. There is an external area for drying these cleaning cloths.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are suitable documented procedures for management of clinical, environmental and civil defence emergencies including a documented service continuity plan. Training in response to clinical and environmental emergencies is undertaken annually by staff.</p> <p>Alternative cooking facilities are available in case of utility failure as gas is available. Food supplies would last three days. Large torches and head lights are available. Sufficient extra blankets are available to keep residents warm until alternative arrangements can be made. Sufficient water is stored for three days use and water tanks are accessible when the water pump is going. An improvement project in relation to the essential emergency power supply availability and resources has been acknowledged ensuring a safer and more efficient emergency system is in place. This was especially important due to the nature of the service.</p> <p>An emergency evacuation plan approval letter was reviewed dated 15 January 2007. The plan of evacuation routes and assembly points is known to staff interviewed. The last fire drill was held on the 22 July 2020 with a good attendance noted. Drills are held for staff six monthly.</p> <p>A call bell is within reach of the resident in each bedroom and in all service areas. Staff are aware of the emergency call sign.</p> <p>This is a secure dementia service and has double door entry and any visitors have to ring and have to be let into the facility by a staff member. Staff routinely check the facility on each shift and hourly rounds of residents occurs for safety purposes. External and internal communal areas have security cameras installed.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	The facility was observed to be light and airy and well ventilated. Each individual bedroom has a large window providing natural light. Wall mounted heaters high up on the walls for resident safety, are available in the lounges, dining areas and in each individual resident's room. The facility maintains a

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		strict non-smoking policy.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The facility has been divided into three wings to form small groups to help with management of social distancing to meet the Covid-19 pandemic infection control measures. The programme is guided by a comprehensive and current infection control manual, with input from external specialist consultants. The infection control programme and manual were reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality committee meetings monthly. This committee includes the facility manager, IPC coordinator and the support supervisor.</p> <p>There was signage at the main entrance to the facility that requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Current information on the Covid-19 pandemic infection control measures was clearly displayed for staff and visitors to see. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills and knowledge and has attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate personal protective equipment was sighted on the days of the audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in November 2020 and included appropriate referencing.</p>

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.		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. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Additional staff education was provided in response the Covid-19 pandemic. Education with residents was provided on a one-to-one basis and has included reminders about handwashing.
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	Bethany Hill Dementia Care's infection surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented on the infections report form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager. Data is benchmarked externally with a specialist provider. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. No infection outbreaks have been reported since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The senior registered nurse is the restraint coordinator for the facility. There is no reported restraint used at the facility. Staff interviewed

use of restraint is actively minimised.		were fully aware of how to safely manage both restraints and enablers, should they be required, and annual education is presented which includes management of challenging behaviours.
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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	CI	Bethany Hill is located in a rural setting. Water is supplied by rain and underground bore water. When there is a power cut, which happens regularly, a generator is needed to light up some parts of the facility, especially when this event happens at night. Since the previous audit after experiencing some events a decision was made to ensure staff would not have to go underneath the building to start up the generator and connect the lines needed. This was considered unsafe practice and the service was left one staff member down when an event occurred whilst the staff member changed the resources over as not automatically controlled.	Having fully attained the criterion the service can in addition clearly demonstrate that the significant changes made to the emergency alternative energy and utility resources in the event of the main supplies failing has benefited both the staff and residents. Three main issues were identified for the existing processes in place. Issues included the inappropriate size of the generator in place at the time attributing to limited emergency power, lighting and heating available in the event of an emergency. The risk of injury as staff had to crawl underneath the facility to connect the line to the water pump and an extension cord to be connected to the inside of the facility. The staff member then needed to connect flood lights in different places by running additional extension cords through corridors and to the kitchen as well. A health and safety issue was identified as there was inadequate power, to light up corridors and toilets. Residents would become agitated when time was prolonged. On evaluation after a power outage of the current system, a plan was

			<p>developed to make improvements. Six goals were set and all were actioned and achieved. This resulted in improvements for staff and residents. To achieve this, a larger generator was installed and relocated, additional lights were installed outside and inside one toilet in each wing, three lounges and two lights in the kitchen. The power outlet for the water pump was relocated and was made accessible for staff. When the generator is started, power, lights and water are then immediately available. The facility is now a safer environment with no extension cords lying around and with effective lighting the residents' all of whom have dementia, are calmer and have normal freedom of movement and can still access their rooms, toilets and other normal places in any emergency situation.</p>
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End of the report.