Capella House Limited - Capella House

Introduction

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

The audit has been conducted by Q-Audit Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Capella House Limited
Premises audited:	Capella House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 August 2021 End date: 5 August 2021

Proposed changes to current services (if any): One room was reconfigured to extend the main lounge in the Dementia wing reducing the beds from 19 to 18.

Total beds occupied across all premises included in the audit on the first day of the audit: 37

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Capella House is a privately owned 38 bed aged care facility in Blockhouse Bay, Auckland. The service provides rest home, hospital, and secure dementia care services. The reconfiguration reduced one bed in the dementia unit which resulted in the bed capacity decreasing from 39 to 38 residents. One room was converted to increase the area capacity of the lounge area. There were 37 residents on the day of the audit. Residents and families spoke positively about the care provided. There is an interim facility manager (FM) employed to cover for current FM who is going on maternity leave.

This surveillance audit was conducted against a sub-set of the Health and Disability Services Standards and the service's contract with the district health board. The audit process included a review of policies and procedures, review of residents' and staff records, observations, and interviews with management, staff, and a general practitioner.

There were no areas identified requiring improvement. The area requiring improvement relating to having an approved fire evacuation plan for the new wing before occupancy was addressed.

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.

Open communication between staff, residents, and families is promoted and confirmed to be effective. There is access to interpreting services if required. All family members interviewed stated they were confident that they were kept informed of happenings including unplanned or adverse happenings, any concerns or follow-up, and the outcome.

A complaints register is maintained with complaints resolved promptly and effectively in line with the Code of Health and Disability Services Consumers' Rights (the Code).

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The service is family-owned and run. The FM, director, and clinical nurse manager (CNM) meet monthly to ensure that services are planned, coordinated, and appropriate to the needs of the residents requiring rest home, hospital, and dementia level of care. The purpose, vision, values, and goals of Capella House are included in the business plan that is reviewed annually to determine and review direction and progress to achieve set goals. An experienced and suitably qualified person manages the service.

The quality and risk management system includes the collection and analysis of quality improvement data, identifies trends, and leads to improvements. Staff are involved, and feedback is sought from residents and families. The incident management system captures all incidents, accidents, and adverse events from all wings. Measures are put in place on how to prevent future events.

Policies and procedures support service delivery and were current and reviewed regularly. The appointment, orientation, and management of staff at Capella House are based on current good practices. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing is rostered to meet the needs of the residents which are reviewed each handover.

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.

Each stage of service provision is provided by suitably qualified personal. The clinical manager and registered nurses assess and develop care plans in consultation with the residents and their families. Files reviewed demonstrated that the care provided, and the needs of the residents are reviewed and evaluated. The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings, the planned activities are meaningful to the residents and aim to develop and maintain residents' strengths, skills, resources, and interests. Medicines are safely managed and administered by staff with current medication administration competencies. All medications are reviewed by the general practitioner (GP) every three months or when required. The food service is provided onsite and caters to residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan and dietitian menu review were in place and valid.

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 service has a current building warrant of fitness expiring 22 June 2022. Trial evacuations are conducted every six months, fire extinguishers, sprinkler systems, and hoses are checked by a specialist contracted agency.

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.

Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and guide the safe use of both restraints and enablers. On the day of the audit, no residents were using restraints and two were using enablers. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident. Environmental restraint is monitored for the secure dementia service. De-escalation training is provided for staff for managing residents who may present with challenging behaviour.

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.

There is a documented surveillance programme that is appropriate to the size and scope of the service. All infections are recorded, with data collated each month, and then annually. Analysis and comparisons are made.

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	17	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints management policy and procedures in place that align with the Code. The service's complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints sighted in the register had been resolved. There were three complaints in 2020 and one complaint in 2021. There were no complaints that required the involvement of the health and disability commission (HDC) since the last audit. Complaint's information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and families are advised of the complaints process on entry to the service. This includes written information about making complaints. Family/whanau interviewed describe a process of making complaints that includes being able to raise these at the monthly residents' meetings, putting a complaint (which can be anonymous) in the suggestion box, or directly approaching staff or the facility manager.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	Family members interviewed reported that 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. All this was evidenced 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. The service is registered with New Zealand interpreter services. There were no residents who required the services of an interpreter however 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

provide an environment conducive to effective communication.		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	Services at Capella House are planned to meet the needs of the residents. The service has reduced their dementia beds from 19 to 18. The room was reconfigured to make the main lounge bigger. The service is one of two facilities owned by Heritage Healthcare Limited. The mission statement and goals are displayed at the front entrance of the facility. The facility is currently managed by the facility manager (FM) who reports to the director. The FM will be going on maternity leave for a year, and they have recently recruited an interim FM for a fixed term. The newly appointed FM has been going through orientation for a month. The FM will start managing the service on 13 August 2021 with support from the current CNM and director. The appointed FM has management qualifications such as a certificate in project management, an NZ certificate in Public Health and Health Promotion, and a Certificate in Health Services Management and holds an overseas Bachelor of Pharmacy degree. Previous management roles have been in the NZ Home Care Services Sector. The director, facility manager, and clinical nurse manager meet monthly, and a current strategic and business plan were sighted. The strategic and business plans, which are reviewed yearly, outline the purpose, values, scope, direction, and goals of the organisation. The documents describe annual and long-term objectives and the associated operational plans. Monthly/quarterly reports to the director showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, occupancy, maintenance, quality management, and financial performance. Organisational performance is monitored in an ongoing manner. The facility manager is supported with day-to-day operations by the director and CNM. Capella House currently provides a secure unit of 18 beds for residents with dementia who can mobilise independently and 20 hospital-level residents. There were 37 residents on the day of the audit. At the time of the audit, there were 16 residents assessed as requiring Hospital level of care and 15 residents requiring dementia level of care There were four residents under the age of 65 years, one in hospital care, and three in dementia care. Additional contracts are held with the district health board for the provision of respite and long-term support for chronic health conditions (LTSCHC).
Standard 1.2.3: Quality And Risk Management Systems The organisation has	FA	Capella House has a planned quality and risk management system which is understood and implemented by service providers. This includes satisfaction surveys, incident and accident reporting, health and safety/hazard reporting, infection control data collection and management, and concerns/complaints management. There is an internal audit programme that details a range of audits to be completed each month and template forms are available for conducting each of these audits. Meeting minutes reviewed confirmed regular review and analysis of

an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		quality indicators and that related information is reported and discussed at the management and staff meetings. The FM reports monthly to the director. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed monthly and evidence of this was sighted. Policies and procedures are available to guide staff practice. The FM is responsible for ensuring policies are updated according to a schedule with input from the management team and other applicable staff. Staff interviewed confirmed they can access required policies easily and were informed when policy documents have been updated. Requested policies and procedures were sighted during the audit. Staff are provided with updates on new policies or changes to any existing policy. Policies are based on best practices and are current. The FM and CNM described the process for the identification, monitoring, review, and reporting of risks and the development of mitigation strategies. The FM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.
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	Staff document adverse and near-miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management. There is an open disclosure policy in place. Any communication with family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family/whanau and the GP interviewed confirmed they are notified in a timely manner. The FM described essential notification reporting requirements, including pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. They advised the only notification made to the MOH was for the newly recruited interim facility manager.
Standard 1.2.7: Human Resource Management Human resource management	FA	Human resources management policies and processes are based on good employment practices and relevant legislation. The recruitment process includes reference checks, police vetting, and validation of qualifications and practising certificates (APCs) where required. A sample of seven staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them adequately for their role.

processes are conducted in accordance with good employment practice and meet the requirements of legislation.		Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff training is being provided. There were 13 health care assistants (HCA's) who had completed career force level four, two completed level three and nine had completed dementia online training. Staff reported that they were currently receiving ongoing training to meet the needs of residents requiring dementia level of care. All staff working in the dementia unit had completed the required dementia qualification. Staff performance is monitored, and current annual performance appraisals were sighted in all files reviewed. The RNs are competent and maintain annual competency requirements to undertake interRAI assessments. There is an additional registered nurse who assists in completing interRAI assessment and also covers the other sister facility.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe care to residents, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An after-hours on-call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there was adequate staff available to complete the work allocated to them. Staffing rosters were sighted, with staff on duty to match the needs of differing shifts. The FM is onsite Monday through Friday and CNM is on-call for all clinical issues. At least one staff member on duty has a current first aid certificate and there is RN cover on duty every shift. Staff on every shift are skilled and competent to deliver care safely to residents requiring hospital, rest home, and dementia services.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner that meets current legislation, protocols, and guidelines. The service uses a pre-packed robust medication system. All medication packs are checked by the RN on delivery against medication charts every month. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. GP conducts three monthly reviews of medication charts sighted. All medication records contained a photograph of the resident with the allergy status completed. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly checks and six-monthly stock checks by the pharmacist. Medication is safely stored in locked cupboards and drug trolley. Fridge temperature and room temperature checked and recorded. There were no expired medications on site. A registered nurse was observed administering medicines and complying with required medication guidelines and legislative requirements. All staff who administer medicines were assessed as competent and evidence was sighted. There are no residents who self-administer medications at the service. A self-administration policy is in place for use when required.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Meal services are prepared on-site and served in dining rooms. The four weekly seasonal rotating menus have been reviewed by the registered dietitian. Diets are modified as required and the cooks confirmed awareness of dietary needs required by the residents. Alternative meal options are offered as required. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night on a 24-hour period. The family/whanau interviewed acknowledged satisfaction with the food service. The kitchen was audited and registered under the food control plan, certificate valid. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges, and freezers temperatures are maintained. Regular cleaning is conducted.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The Short term and long-term care plans sampled included interventions appropriate to meet the residents' desired outcomes. Any changes are reported in a timely manner and prescribed orders are carried out as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed, and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving.
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	

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' long-term care plans, InterRAI assessments, and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau, residents, and staff are consulted in the review process. The evaluations record indicates how the resident is progressing towards meeting set goals and responses to interventions. Short term care plans are developed when needed, signed, and closed out when the short-term problem has been resolved
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The only change to the facility since the last audit was the extension of the dementia lounge which resulted in the reduction of dementia beds from 19 to 18. The current building warrant of fitness was sighted, and it expires on 22 June 2022.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Trial evacuations are completed every six months and the last fire drill was conducted on 30 March 2021. Records of staff attendance are maintained. There is an approved emergency evacuation plan. The previous area requiring improvement in relation to the new wing having an approved fire evacuation plan was addressed.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities,	FA	The surveillance programme is defined and appropriate to the size and scope of the service. All infections are recorded in the residents' files using the nosocomial infection data collection form. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits were sighted. Staff interviewed confirmed that they are informed of infection rates as they occur. The GP is informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed

and methods that have been specified in the infection control programme.		infections. There has been no outbreak since the last audit. A pandemic plan is in place and adequate personal protective equipment was sighted. Staff, residents, and families are updated on regular Covid-19 latest information.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	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 clinical manager interviewed provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation`s policies, procedures, practice, and responsibilities. On the day of the audit, no residents were using restraints and two were using enabler grab rail. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident as reported by the CM. Processes are in place if either are in use. Restraint is used as a last resort when all alternatives have been explored. Environmental restraint is monitored for the secure dementia service. De-escalation training is provided for staff for managing residents who may present with challenging behaviour.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.