# Graceful Home Shoal Bay Limited - Shoal Bay Dementia

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Graceful Home Shoal Bay Limited

**Premises audited:** Shoal Bay Dementia

**Services audited:** Dementia care

**Dates of audit:** Start date: 17 August 2021 End date: 17 August 2021

**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:** 21

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

## General overview of the audit

Graceful Home Shoal Bay Limited - Shoal Bay Dementia is one of four aged related residential care services currently owned by the director. The facility provides care for up to 26 residents requiring dementia level care.

This audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies, procedures, residents’ and staff files, observations and interviews with residents, families, a general practitioner, the director, managers and staff.

Three areas were identified as requiring improvement related to complaints management, demonstrating that meetings include discussion on all relevant quality and risk topics, and ensuring all care staff complete an industry approved qualification within 18 months of employment.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

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. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. 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.

Family members are informed of the complaints process as part of the admission process.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

The organisation's philosophy, mission and goals/objectives are documented in the business, quality and risk management plans. The company owner/director works with the two onsite members of the management team including the facility manager and the registered nurse, as well as the clinical manager who works across three out of the four care homes owned by the owner/director. The management team work together to ensure the services offered meet residents’ needs, legislation, and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, satisfaction surveys, complaints management, incident/accident reporting, corrective action planning, hazard management, and infection control data collection. An external consultant develops policies which are reviewed and updated by the registered nurse to reflect the service’s needs.

New staff have an orientation. Staff participate in regular, relevant ongoing in-service education. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met. The service has a documented rationale for staffing which is implemented.

Residents’ information was accurately recorded, securely stored and not accessible to unauthorised people.

## 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. |

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents’ needs on admission. 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. Residents 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. |

Policies and procedures were available to guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment were readily accessible for staff use. Staff have been trained on chemical safety.

The building has a current building warrant of fitness. Clinical equipment has current calibration. Hot water is within the required temperature range and is monitored. There are internal and external security cameras in use.

There are 26 single occupancy bedrooms. All have hand washing facilities. There are sufficient bathrooms for residents’ use including some rooms with shared or individual ensuite toilets. Call bells were present in the bedrooms and bathrooms.

Personal space was sufficient for residents, including those who require staff assistance. There is an open plan lounge and dining area. There is indoor/outdoor flow with a secure internal garden area for the residents and their families to use. The facility has adequate heating and ventilation. Smoking is only allowed in a designated external area with staff supervision.

Cleaning and laundry services are provided. These services were monitored through the internal audit programme. Residents and family members interviewed confirmed the facility was kept clean and warm.

Emergency policies and procedures provided guidance for staff in the management of emergencies. There is always a staff member on duty with a current first aid certificate. There is an approved fire evacuation plan and fire evacuation drills are conducted at least six monthly. Sufficient supplies are available on site for use in the event of emergency or an infection outbreak.

## 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. |

Restraint and enablers are not used on site as this is a secure dementia service. There were no restraint or enablers in use at the time of the audit. Staff are provided with training on restraint minimisation and managing behaviours that challenge.

## Infection prevention and control

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

The infection 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 | 42 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 2 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Graceful Home Shoal Bay Limited 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, providing options, and maintaining dignity and privacy.  Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. The last training session on the Code was conducted in September 2020, as verified in training records.  Caregivers were observed calling residents by their preferred name. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent forms as needed.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident’s record. Resident files had evidence of enduring power of attorney (EPOA), and these had been enacted.  Staff were observed to gain consent for day to day care activities, and could appropriately detail how they would respond to refusal of care, medicines or food/fluid. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family and staff members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment events in the community.  The facility has unrestricted visiting hours and encourages visits from residents’ family and friends, except when otherwise indicated to comply with the Covid-19 National Alert Level in place at the time. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.  Even though there were visitors’ restrictions recently due to the pandemic, residents and family members interviewed stated they felt comfortable about the way it was managed and were kept well informed. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | Shoal Bay Dementia has a complaints policy and procedures that complies with the Code. During interview, family members confirmed they are aware of the complaints process and noted they had no complaints. One family member noted they had emailed the manager to clarify an issue related to the admission agreement. Complaints and compliments forms are present near the main entrance and include an area for the recording of complaints and compliments. Staff are provided with information on the complaints process during their orientation and as part of the ongoing education programme.  A complaints register is maintained but does not include all applicable information. Complaints are noted as being closed on the day of receipt despite ongoing actions being required to address the complaint issues. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and during discussion with staff.  The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff were observed to maintain privacy throughout the audit, when attending to personal cares, by ensuring residents’ information is held securely and privately, when exchanging verbal information and in discussions with families. All residents have a private room.  Residents are encouraged to maintain their independence through community activities and regular outings. Care plans included documentation related to the resident’s abilities, and strategies to maximise independence.  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.  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. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current organisation wide policy on Māori health to guide the facility on the development of individual resident Māori health plans (where applicable). There is a commitment to providing culturally appropriate services that starts with the owner/director who has personal affiliations with Iwi.  Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.  Family members interviewed reported that staff acknowledged and respected their individual cultural needs. Guidance on tikanga best practice is readily available. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Family members interviewed verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences, required interventions and special needs were included in care plans reviewed.  The resident satisfaction survey confirmed that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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. Ongoing education is provided on an annual basis which was confirmed in training records sighted.  Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation, abuse or neglect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist and 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.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family members stated they were kept well informed about any changes to their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed.  Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff knew how to access interpreter services, through the district health board, if needed. There are staff members who can speak te reo Māori. Staff reported interpreter services were rarely required due to all present residents being able to speak English and/or te reo Māori. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The business, quality and risk management plan details the mission, values, philosophy, scope, and nine goals and objectives of the organisation.  The owner/director, and the three other members of the Shoal Bay Dementia management team (facility manager, registered nurse and clinical manager), monitor performance and progress towards achieving the goals. This includes via evaluating occupancy rates, staffing, ongoing education/training, risks and issues, incidents and accidents, concerns/complaints, and health and safety.  The owner/director has approximately seven years’ experience in providing aged related residential care (ARCC) at rest home and dementia level of care. Shoal Bay Dementia (SBD) is one of four aged related residential care services owned by the director. The owner/manager is satisfied that relevant issues are being raised by the management team in a timely manner.  The facility manager has been in the role since March 2020, and previously worked in one of the owners’ other businesses. The facility manager is supported by the owner/director. The facility manager’s responsibilities are detailed in a position description. The facility manager works full time at SBD and has attended more than eight hours of relevant education in the past 12 months.  The registered nurse works full time at SBD, is responsible for providing oversight of the clinical care provided to residents and ensuring their day-to-day clinical needs are met. The registered nurse (RN) has worked in this facility for three months and is being mentored by the clinical manager. The clinical manager was employed in March 2021 and works across three of the aged related residential care facilities owned by the owner/director. The clinical manager has current interRAI competency and is an approved assessor for staff completing an industry approved qualification.  Shoal Bay Dementia has an Aged Related Residential Care (ARRC) Contract with Waitemata District Health Board (WDHB) for the provision of dementia care services. There are 21 residents receiving services at audit. This included 19 residents receiving services at dementia level of care under the ARCC contract and two residents that are funded under mental health.  During audit, community transmission of Covid-19 was identified as occurring in Auckland. This certification audit, that was scheduled to occur over one and a half days was continued until completion, later on the first day/evening, after discussion with the management team. During this time the management team worked to implement the additional precautions required by the National Covid Alert Level Four for residents and staff safety. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the facility manager’s absence, the registered nurse is responsible for the services delivered with the support of the clinical manager and the owner/director. There are very experienced health care assistants (HCA’s) in team leader roles that assist the RN with day to day activities as and when required. The RN confirmed that appropriate supports are available. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Shoal Bay Dementia has a quality and risk management system which is understood and implemented by service providers. This is linked to the objectives and quality improvement plan and goals. Quality related objectives are identified. The quality and risk programme includes compliments and complaints management, internal audits, satisfaction surveys, incident and accident reporting, hazard management, health and safety, infection control data collection and management. The facility is restraint free. Regular internal audits are conducted, which cover relevant aspects of service, including aspects of care, medication management, documentation, and laundry and cleaning services. There was a high level of compliance in the audit outcomes sighted. A family satisfaction survey occurred in July 2021.  Policies and procedures are available for staff. These have been developed by an external consultant and then reviewed and localised to reflect the needs of Shoal Bay Dementia. The registered nurse is responsible for document control processes. Policies and procedures are discussed where applicable during orientation and as part of the staff education programme.  If an issue or deficit is found, a corrective action is put in place to address the situation, although these have not been appropriately documented in response to complaints. Refer to the area for improvement raised in criterion 1.1.13.3.  Quality information is shared with all staff via shift handover and in the communication book. The minutes of the management team meetings, (attended by the owner/director, facility manager, registered nurse, clinical manger and administrator), held since February 2021 could not be located. While some quality information is discussed at the monthly staff meetings, this does not include internal audit and satisfaction survey results and changes to existing policies and procedures when applicable.  Actual and potential hazards/risks are identified in the hazard register. The hazard register and mitigation strategies have been recently reviewed. There is also a hazardous substance register. Organisation risks are documented and reviewed at least annually or sooner where indicated. The director/owner discussed the issues related to the Covid-19 pandemic and initiated a range of precautionary measures before these were officially recommended in 2020. Prior to entry, visitor and staff screening for Covid risks and a temperature check are undertaken. There is an electronic system that includes facial recognition of registered visitors (staff, contractors and family members) and temperature scanning at the front entrance. For casual visitors a manual process is being implemented. The owner/director is satisfied any concerns or risks about services at Shoal Bay Dementia are being identified and communicated in a timely manner. During audit, in response to reports of community transmission of Covid-19, the precautions in place were escalated. |
| 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 | Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.  Applicable events are being reported by staff. The registered nurse is responsible for investigating the reported events and implementing any required care in a timely manner and disclosing the events to the resident and/or designated next of kin. Family members interviewed confirmed they are kept informed in a timely manner of any events or changes in their relative’s health status. A review of reported events including for challenging behaviour, unwitnessed falls (with and without injuries), a bruise, a medicine error, and a pressure injury, demonstrated that incident reports are completed in a timely manner. The RN has investigated and responded to the adverse events/incidents reported since the RNs employment. The RN has also worked to investigate and follow up the applicable events reported in the three months prior to the RN’s employment, that had not been fully completed. Neurological observations are occurring post unwitnessed falls sampled.  Staff advise they communicate any incidents and accidents to staff on the next shift during handover. The number and type of reported incidents/events have been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted.  The clinical manager, owner/director and facility manager could identify the types of events that are required to be reported as an essential notification to external agencies including the Ministry of Health. The notification that has been made was discussed and related to the notification of the change in facility manager with an acknowledgment letter from the Ministry of Health (MOH) sighted dated 18 March 2020.  One resident with a pressure injury was notified to the DHB, and wound care support obtained from the wound care specialist. There have been no other events requiring notification. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Human resources management policies and processes are based on good employment practice and relevant legislation. Recruitment of new staff is undertaken by the management team including the owner/director. The recruitment process includes staff completing an application form, interviews, conducting reference checks, police vetting (with records held by the administrator), having an employment contract and job description. The employment contract includes a statement advising staff of privacy and confidentiality requirements.  All employed and contracted registered health professionals have a current annual practising certificate (APC).  Staff were provided with an orientation programme that includes all necessary components relevant to the role. This includes spending time with the management team, being buddied with a senior staff member and working through the documented check list. Staff reported that the orientation process included a period of being buddied with a senior staff member for each shift the staff member will be working. Information shared includes orientation to the facility, individual resident needs, safety/security and emergency processes, and the shift duties/schedule. Staff advised the orientation programme suitably prepared them for their role and responsibilities. All except one staff member has a current annual performance appraisal.  There is a comprehensive ongoing education programme that includes the topics to meet ARRC contract requirements. However, not all care staff have completed an industry approved qualification within 18 months of employment as required to meet ARRC contractual requirements. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider’s contract with WDHB. The owner/director develops the roster and sends it to the facility manager for review and finalising. There were three HCA shifts vacant on the current roster. Staff volunteer to work these or other shifts where staff have advised they will be absent from their scheduled shift, with one exception noted in the sampled rosters. The exception was not related to a night duty.  The rosters for a five-week period were reviewed. The registered nurse works five mornings a week with rotating rostered days and is available on call when not on site. The facility manager works weekday mornings. The clinical manager visits weekdays at present. The clinical manager has a current interRAI competency. The RN has completed interRAI training and has submitted the required assessments and is awaiting review and verification.  There is a cook on site daily from 8 am to 5 pm, shared by two staff. Two cleaners share the cleaning and laundry roster, covering the full week between 6 am to 2.30 pm daily. An administrator works three days a week.  There is a minimum of two HCAs on duty at all times. There are currently four HCAs rostered on the morning and the afternoon shifts with two staff working a full shift (eight hours) and two HCAs working a part shift (six hours).  A staff member is responsible for the activities programme for 30 hours a week over five days.  A staff member with a current first aid certificate and medicine competency is always on duty. The owner/director advised that additional staff hours are allocated to meet the care needs of the residents as and when required, or for increased occupancy.  The family members interviewed confirmed their relative’s care needs were being well met.  Not all applicable staff have completed an industry approved qualification in dementia care within 18 months of employment as required to meet the ARCC contractual requirements. This is raised as an area for improvement in criterion 1.2.7.5. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents’ information sighted. All necessary demographics, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment entered into the momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a catalogue system. Residents’ records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Specialist referral to the service is confirmed by sighting letters from mental health for older adults team confirming the level of care. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and the GP for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission.  Files reviewed contained completed demographic detail, assessments, EPOA had signed admission agreements and consented for admission. Service charges comply with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. 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 resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Family members interviewed reported of being kept well informed during the transfer of their relative. |
| 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 policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic 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. Regular medication audits are completed and are followed with appropriate corrective actions. There was evidence of pharmacy involvement. Residents are not able to self-administer medications due to their assessed level of care.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.  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 and six monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Vaccines are not stored on site.  Good prescribing practices noted included the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.  There is an implemented process for comprehensive analysis of any medication errors. |
| 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 | The food service is provided on site by a qualified chef who is supported by an experienced cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in June 2021.  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 Ministry of Primary Industries effective from 27 November 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have completed safe food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food, snack foods, and fluids to meet their nutritional needs over each 24 hour period. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.  If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the GP and whānau/family. Examples of this occurring were discussed with registered nurse (RN) and clinical manager.  There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents are assessed to develop an initial care plan. Within three weeks of admission a comprehensive assessment is completed using nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and interRAI, as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by a trained interRAI assessor on site.  Files audited have evidence of wound management, such as a wound care plan and evaluation. Evidence of wound management, including photographs of chronic wounds, was sighted. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | 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. Residents’ files had documented dementia specific 24-hour care plan and behavioural management care plans including triggers and interventions for behaviours of concerns.  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 is documented and verbally passed on to relevant staff. Family members reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentations, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by an activities coordinator who is currently training to be a registered diversional therapist (DT). A wide range of activities are provided seven days a week.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as part of the formal six-monthly care plan review. A life story book including past likes and important past events was completed during the admission. An individualised 24-hour activities plan was completed by the activities coordinator and is reviewed as part of the six monthly care plan review.  The weekly activities planner sighted matches the skills, likes, dislikes and interests identified in the assessments. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through care plan reviews and satisfaction surveys. Family members interviewed confirmed the residents enjoy the programme. Residents were observed actively participating in the planned activities occurring during audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted.  When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. The service has a contracted GP who visits weekly. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files. All referrals are followed up by the GP or RN. The family/whānau are kept informed of the referral process, as verified by documentation and interviews.  Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Policies detail how waste is to be segregated and disposed. The policy content aligns with current accepted practice. There is a hazardous substance register.  Chemicals sighted were stored in designated and secure areas. Safety data sheets were sighted for chemicals in use. Staff have been provided with training on chemical safety and handling during orientation and as part of the ongoing education programme where relevant.  Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, masks, and eye protection.  Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids to the manager. Staff confirmed receiving education on handling chemicals and waste as part of the orientation and ongoing education programme. |
| 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 building warrant of fitness has an expiry of 6 September 2021. The facility footprint is over four levels, with the laundry and main entrance on the lower ground level. There is a short staircase to the main floor where most of the residents’ bedrooms, bathrooms (including shower), and the open plan lounge and dining area are located. There is a secure internal courtyard on this level, with appropriate shade and furniture. There is another short staircase to a floor where there are five residents’ bedrooms (three have a toilet and hand basin ensuite), another bathroom with a toilet and shower, and the main kitchen is located. The uppermost level (attic) is used by the director/manager as an office area and cannot be accessed by residents.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The owner/director has been undertaking a programme of refurbishment and maintenance of bathroom and communal areas and as residents’ rooms become vacant.  Calibration of bio medical equipment was current as confirmed in documentation reviewed, and observation of the environment. Electrical test and tagging has been completed. Hot water temperatures are monitored monthly on a rotating basis in resident care areas and are within the required range. The environment was hazard free, residents were safe, and independence is promoted. Grab rails are present in all the bathrooms, hallway and on both sides of the stairs.  The facility does not have a vehicle but uses the vehicle of another ARRC facility owned by the owner/director when required.  External deck and garden/courtyard areas are safely maintained and were appropriate to a secure dementia service.  Staff confirmed they know the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they were happy with the environment. The maintenance book verified that timely action is taken to address any facility or equipment related maintenance requests. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | Sixteen residents’ bedrooms on the main floor have a shared ensuite toilet and handbasin between two bedrooms, and three bedrooms on the upper floor have their own ensuite toilet. There are adequate numbers of bathroom facilities including showers throughout the facility.  Privacy locks are present on the doors. Staff can override these if required for resident safety.  Hand basins are present in each resident’s bedroom or ensuite. Appropriately secured handrails are provided in the toilet/shower areas.  There are separate toilet facilities for staff and visitors to use. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around bedrooms safely. All bedrooms are single occupancy. Rooms are personalised with furnishings, photos and other personal items displayed. Residents were sighted mobilising inside and outside the facility independently or with staff support.  The staff interviewed advised there is sufficient space for the residents to mobilise inside and outside the building, including when assistance was required. The residents on the upper floor are physically very mobile and able to independently walk up and down the stairs safely. The RN is responsible for assessing the appropriateness of residents allocated bedrooms on the upper level.  The health care assistants detailed a process of ‘regular rounding’ to visually check on all residents throughout the day and night.  The family members interviewed confirmed the environment is comfortable and well maintained. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is an open planned lounge and dining room for residents’ use. There is an external garden and deck areas that has clusters of appropriate furniture and shade. The residents and family members interviewed confirmed they enjoy the spaces available. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Policies and activity/duty lists detail how the cleaning services are to be provided. The residents’ personal clothing is washed daily onsite by designated staff. There is one washing machine and one clothes drier on site in the laundry room that is secure from unauthorised residents’ access. Chemicals are stored safely. Facility linen is washed by an external contractor and returned, with laundry collection and deliveries occurring three days each week (Monday, Wednesday and Friday).  The residents and family members interviewed confirmed the facility is kept clean and tidy and residents’ laundry is normally washed and returned in a timely manner. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated a high level of compliance with the service requirements.  The two HCAs, the team leader, and the cleaner interviewed confirmed being provided with training on the safe handling of chemicals and had written instructions, and safety instructions readily available on the use of products and required cleaning processes/activities. One of the staff responsible for cleaning and laundry services has worked on site for 16 years in this role. There is a cleaning schedule to ensure all residents’ bedrooms get a full clean at least once a week and a spot cleaned in between. Bathrooms are cleaned at least daily, and more frequently if required. The other living areas are cleaned at least daily.  Instructions for managing emergency exposures to chemicals is readily available to staff. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are known by staff. These include reference to the special needs of residents in a secure dementia service. A register is maintained of the name and photograph of each resident and any specific assistance required in the event of an emergency. This is kept updated.  A fire evacuation plan was approved by the New Zealand Fire Service with a letter to the provider verifying this sighted; dated 10 October 2013 (EV-2013-03603-03). A trial evacuation takes place six-monthly. The most recent fire drill was conducted on 17 March 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures, including what they would do if a resident could not be located.  Adequate supplies for use in the event of a civil defence emergency, including dry food for at least three days, water, blankets, continence products, other commonly used consumables, meet the requirements for up to 26 residents.  Call bells alert staff to residents requiring assistance via sensor mats that alert staff that a resident is trying to get out of bed. Staff can utilise bells to access assistance if required. The call bells alert via an audible sound and notification of the room number/location through to centralised panels.  Appropriate security arrangements are in place. Signage alerts visitors that security cameras are in use. Security cameras monitor external areas, entrances and corridors/communal areas. The facility manager has access to the images including remotely. One resident has a wander search device in use. This was utilised for a resident prior to their admission and is kept operational at the family’s request. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Sampled windows all had security stays installed. Heating is provided by wall mounted panels or underfloor or ceiling mounted central heating. Staff are responsible for ensuring the temperature is maintained at a comfortable level. Areas were at an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. During audit the ambient temperature throughout the facility ranged from 23.5-25.5 degrees Celsius.  Smoking is only allowed under supervision of staff. There are two residents that currently smoke tobacco. Staff are responsible for storing the cigarettes and lighter devices. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Shoal Bay Dementia implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.  An RN 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. Infection control data is discussed during the staff meetings and a copy of the minutes are available for staff. This infection control committee includes the RN, health care assistant and clinical manager.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Due to Covid-19 pandemic (currently level 1, on the day of audit), all visitors are requested to log their visit by entering their details on a paper log or by scanning a Ministry of Health bar code. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The IPC coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There were no infections disease outbreaks reported in the facility since the last audit. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed annually and included appropriate referencing.  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 are 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 in 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.  When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. In response to the recent pandemic, staff have completed training on the Covid-19 pandemic, hand hygiene, isolation precautions and use of personal protective equipment.  Residents are encouraged and reminded about handwashing and increasing oral fluids during hot weather. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. The IPC coordinator reviews all reported infections and these are documented. 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, and comparisons against previous months and this is reported to the clinical manager and staff. The monthly infection rates remained low. There was evidence of staff education on ‘chain of infection transmission’ following an increase in number of infections.  Covid-19 pandemic preparedness document was sighted and staff interviewed were aware of this plan. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Shoal Bay Dementia has a policy and procedure available for staff on the use of restraint and enablers. Definitions of restraint and enablers aligns with the standards. The policy notes a commitment to having a restraint free environment at Shoal Bay Dementia, with the exception of environmental restraint which is appropriate for residents requiring secure dementia care.  Staff are provided with training on the restraint and enabler policy during orientation and as part of the ongoing education programme and confirmed restraints and enablers are not used. Staff have also been provided with training on managing challenging behaviours (October 2020) and were observed to engage with residents in a meaningful way with activities, diversion, and distraction where applicable. Family members interviewed confirmed staff interact with their family member in a respectful manner. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Seven complaints were received over approximately a five week period and related to the same issue. This included a complaint received via the district health board. The complaints register notes each complaint was closed on the same day the complaint was received. This was incorrect. The facility manager and director detailed a range of initiatives that were undertaken in response to the complaints during the time these complaints were being received. However, the actions taken to address the complaints have not been documented in the complaints register.  There have been no complaints received from the Ministry of Health (MOH) or the Health and Disability Commissioner (HDC) since the last audit. | The complaints in the complaints register are incorrectly noted as being closed on the date the complaint was received and before all required interventions have been completed and monitored for effectiveness. The complaints register does not include details of all actions taken. | Ensure complaints are only closed after appropriate actions have been taken to address the complaint. Ensure the complaints register includes details of actions taken in response to every complaint.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The management team are reported to meet monthly. Minutes of management meetings since February 2021 could not be located. The management meeting minutes sighted dated 15 December 2020 and 17 February 2021 had a variety of topics discussed and did not include discussion on the results of internal audits, the satisfaction survey, policy or procedure changes, and accidents and incidents (including analysis) except for a medication related event.  Regular staff meetings are held. The results of internal audits, satisfaction survey, policy and procedure changes are not explicitly included as being discussed where relevant to the attendees’ roles. Discussion is noted on the number and type of accidents and incidents and associated themes and trends, and infection surveillance data. | The minutes of management meetings held since February 2021 could not be located.  The results of internal audits, satisfaction surveys and changes in policy are not explicitly noted as being discussed in the meeting minutes sighted. | Ensure records are maintained of the discussions included in the management meetings.  Ensure the results of internal audits, satisfaction survey and amendments to existing policy are discussed at applicable meetings and appropriate records maintained.  180 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There is a comprehensive ongoing education programme that includes the topics to meet ARRC contract requirements. Topics included in the last 12 months included manual handling, defining and recognising frailty, palliative outcome initiative (POI), infection prevention and control, behaviours that challenge, the Code of Rights, fire safety, privacy, first aid, preventing cross infection in the kitchen, manual handling, medicine competency, pressure injury prevention and management and cardiac disease. Education is provided by the management team and external speakers including the gerontology nurse specialists. Records of attendance are maintained  Four staff have an industry approved qualification in dementia care, and one staff has a different level four industry approved qualification. Four staff are currently working towards gaining an industry approved qualification in dementia care. Two staff have worked at Shoal Bay Dementia for over 18 months and have yet to complete this qualification. Another staff member employed for 17 months has yet to be enrolled.  The activities coordinator is working towards completing an industry approved qualification in diversional therapy. | Two staff have not completed an industry approved qualification in dementia care within 18 months of employment. One staff member employed for 17 months has yet to be enrolled. | Ensure all care staff complete an industry approved qualification in dementia care within 18 months of employment.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.