# Avonlea Trust Board

## 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 Health Audit (NZ) 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:** Avonlea Trust Board

**Premises audited:** Avonlea Hospital and Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 October 2015 End date: 23 October 2015

**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:** 49

# 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

Avonlea is administered by the Avonlea Trust Board, located in Taumaranui, and provides rest home and hospital level of care for up to 50 residents.

This surveillance 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 and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management and staff.

No shortfalls were identified at the previous certification audit and no new shortfalls were identified at this audit. Feedback from residents and family/whānau members was positive about the care and services provided.

## Consumer rights

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| 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. |

Communication with residents is open and honest, reflective of the service’s open disclosure policy. The service implements processes for contacting interpreting services when this is required. The service has policies and procedures in place which identify how complaints are to be documented, reviewed, followed up and addressed.

## Organisational management

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| 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 managed by a suitably qualified and experienced facility manager. The organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents’ needs.

The quality and risk system and its processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. The quality management system includes an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements. Staff receive ongoing education that reflects current accepted good practice.

## Continuum of service delivery

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| 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. |

Care and interventions are provided in time frames that meet the resident’s needs and contractual requirements. The documented care plans are based on the assessed physical, psycho-social, cultural and spiritual needs of each of the residents. The care is evaluated at least six monthly, to ensure the residents are responding to meeting their identified goals. When changes in needs occur, interventions are updated and changed as required. Staff demonstrated knowledge in providing interventions and services for the residents.

Planned activities are based on the interests and strength of the residents. The food and nutritional services are provided to meet the needs of the older person living in the long term care environment. Medicines are safely managed to meet legislation and best practice guidelines. Staff who assist in medicine management are assessed as competent to perform their role.

## Safe and appropriate environment

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| 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 building has a current building warrant of fitness. There has not been any change to the layout of the building that has affected the building warrant of fitness or approved evacuation scheme.

## Restraint minimisation and safe practice

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| 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. |

When enablers are used they are voluntary and the least restrictive option to maintain the resident’s independence, safety and mobility. Restraint and enabler use is clearly documented in the resident’s care plan.

## Infection prevention and control

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| 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 monthly surveillance of infections. This infection data is collated and analysed. When trends or an increase in infections are noted, actions are implemented to reduce the reoccurrence. Staff demonstrated sound infection prevention and control practices and knowledge.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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).

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| **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 | There are complaints forms available and easily accessible and displayed at the reception area. The complaints sampled comply with time frames of Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Where possible the organisation tries to exceed this time frame and address any complaints within two working days.  The residents and families reported that it is easy to make a complaint if they wish to. Staff demonstrated awareness of how to manage a complaint. Complaints have been received through the formal complaints form, verbal or email feedback.  The complaints sampled included the nature of the complaint, investigation, actions taken and follow up to the complainant. The complaints register records the dates, complaints and how they were addressed. There has been one external complaint in 2014 through the Health and Disability Commissioner (HDC), which is now closed, there was no follow up required from the HDC. The service has implemented a stronger falls prevention programme as an outcome of the external complaint. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The residents and family/whānau reported they receive full and frank information from the staff. Family/whānau confirmed they were kept informed of the resident's status, including any events adversely affecting the resident. There are regular resident meetings with the advocacy service, where feedback was provided to management, the staff and board as appropriate. There is evidence of open disclosure as documented on the accident/incident forms and in the residents' progress notes.  Wherever necessary and reasonably practicable, interpreter services are provided through the DHB. All residents communicate effectively in English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Avonlea is owned by the community and governed by a Trust Board made up of members of the community. Avonlea provides rest home and hospital level of care for up to 50 residents. At the time of audit there were 49 residents, which include 33 rest home and 16 hospital level of care. One of the hospital level of care residents is admitted for palliative care. There is one long term resident who is under the aged of 65. Services are planned to meet the needs of each the residents.  The purpose, values, scope, direction, and goals of the organisation have been clearly identified. The vision, mission and values are documented and displayed. The strategic plan and operation plan contains five year and 10 year goals. The strategic plan and operational plans are formally reviewed annually by the board. The manager reports against these plans at the two monthly board meetings.  The service has joined other not for profit trusts who operate aged care facilities across the Waikato regions. This joint community trust enables the managers to meet each six to eight weeks to discuss aged care issues, support each other and provides bulk buying of resources and equipment.  The facility is managed by a suitably qualified and experienced manager, who is a registered nurse. The manager has been in the role for 8 years and attends continuing education to maintain nursing registration and specific education related to the management of an aged care facility. The manager was attending an offsite meeting at the time of audit and was interviewed via telephone.  The facility manager is supported by a clinical nurse leader who is a registered nurse. The clinical nurse leader has completed the interRAI training. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk management systems cover the key components of the service delivery. There are separate infection control, health and safety and restraint meetings. The quality meeting further reviews all the outcomes and issues reviewed at each of the other meetings. The quality and risk management systems are monitored through an internal auditing schedule, quality action reports, feedback from complaints and review of incidents and accidents. Internal audits include the objective, method, results and recommended actions and follow up to ensure the actions are effective. Information is shared with all staff with meeting minutes and results displayed on the staff notice board.  Quality improvement data is collected, analysed, and evaluated by the appropriate committee (such as health and safety, restraint) then also reviewed at the quality meeting. The internal audits sampled evidenced corrective planning to address any shortfalls. Feedback is provided to the appropriate levels of staff, for example food services to the cook, clinical audit outcomes to the caregiving staff.  Policies and procedures are developed by an aged care consultant and reviewed over a two year cycle by the manager, quality coordinator and the clinical leader. The reviews can occur earlier to reflect any changes to legislation or best practice. Staff only have access to the most recent policy, with all documents version controlled.  Staff, residents and family/whānau confirmed any concerns they have were addressed by management and gave verbal examples of quality improvements made.  Actual and potential risks were identified and documented in the hazard register. There were interventions implemented to either eliminate, isolate or minimise the hazards. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. |
| 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 understand their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. There have been some incidents or accidents that have required essential notification. Staff reported they report and record all incidents and accidents.  Incident and accident reporting processes are well documented and any corrective actions to be taken were shown on the forms used by the service. Families are notified of any adverse, unplanned or untoward events at times they have nominated. Family/whānau confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Management confirmed that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. Any incidents of pressure areas are reported through the incident reporting system, At the time of audit there were two residents with pressure injuries, one resident who was admitted with the injury and another who has a long term pressure injury (for over 4 years), with strategies being implemented to reduce pressure and progress towards healing the wound. |
| 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. | FA | Staff who require professional qualifications and annual practising certificates (APCs) have these validated as part of the employment process. A register is maintained of the staff and contractors who require an APC, with current APCs sighted for all staff that require them.  Policies and procedures are implemented for human resources management that reflects good employment practice and meets the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles.  Staff undertake training and education related to their appointed roles. Records of attendance and competency training are maintained. Education provided is refined to current accepted good practice, with staff providing feedback and evaluation of the in-service education provided. The education programme covers the contractual requirements, staff competencies and specific issues related to the aging process. The service has completed the required RN training on the interRAI assessment tool for the clinical nurse leader. InterRAI training for other RNs is planned. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy identifies staffing levels and skill mix are maintained to meet residents’ needs and to comply with the funder’s contractual requirements and safe staffing guidelines. Rosters identified that at all times there are adequate numbers of suitably qualified nursing and care staff on duty. Staff are allocated per each wing of the facility for morning and afternoon shifts, with staff rostered for the whole facility at night. A review of rosters showed that staff were replaced when on annual leave or sick leave. There are appropriate numbers of administration, activities and cleaning/laundry staff to meet the needs of the service and residents.  Residents stated their needs are met in a timely manner. Some care staff did report that they can be very rushed and sometimes are not able to get through all their required duties each shift, they do report that there is good team work and staff on other shifts are available to assist when they are busy. |
| 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 | Medicines are delivered from pharmacy in pre-packed dispensing systems. A safe medicine management system that complies with legislation and aged care safe practice guidelines was observed. Medications and controlled drugs are securely stored. There are no standing orders. All medications are individually prescribed and dispensed in the pre-packed system. Each medicine prescription and medication record has the required information and details to comply with legislation. Medication reviews have been documented at least three monthly on the medication charts.  Residents who self-administer their medications have a monthly competency review and assessment. Staff demonstrated competency with medicine administration at the time of audit. When there has been medication errors, interventions and corrective actions are implemented to ensure staff have continued competency to administer medications. |
| 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 menu is reviewed by a dietitian as suitable for older people living in long term care facilities. The service has a weight management programme which monitors unexpected weight loss. Where unintentional weight loss is recorded or the resident has a specific need, the resident is referred for a dietitian review. At the time of audit there was no unintentional weigh loss. The kitchen manager reported that they are included in the monthly MDT meetings with residents and family/whānau.  A nutritional profile is completed for each resident by the staff on entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. The residents and family/whānau reported they are satisfied with the food and fluids. The internal audits, quality monitoring and resident surveys of the meals evidence satisfaction with the meals provided.  All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. |
| 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 care plans clearly describe the interventions and services to meet the resident’s needs. The service has implemented the required electronic interRAI assessment for all residents. The service uses the interRAI and other relevant assessment tools to create the care plan. The care plan format includes interventions for the residents assessed physical, psycho-social, cultural and spiritual needs. Staff demonstrate knowledge of the interventions required for each resident. The residents and family member reported satisfaction with the care and interventions provided. |
| 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 residents were observed to be participating in meaningful activities. There are planned activities five days a week, with some community activities occurring over the weekends. The diversional therapist reported they seek feedback from residents during activities, one to one talks and resident meetings to ensure the current programme is meaningful to the residents. The diversional therapist has incorporated this feedback to make some of the residents ‘wish list activities’ to the activities plan. The residents and family/whanau reported satisfaction with the amount and variety of activities. Some residents did report that they felt there could be more planned activities over long weekends.  The diversional therapist reported the activities are modified according to the capability and cognitive abilities of the resident, with examples given of how activities have been modified for residents with sight impairment. The activities programme covered physical, social, recreational and emotional needs of the residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluations are recorded on the care plan. The evaluation of care described how the resident is progressing towards meeting their goals. Where progress is different from expected the service uses a short term care plan to identify and record these temporary needs. If the change is ongoing, this is recorded and updated on the long term care plan. Short term care plans were sighted in the files reviewed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness displayed. There have not been any changes to the layout of the building that have required changes to the approved evacuation scheme. |
| 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 | There is monthly surveillance of infections. The service uses standardised definitions appropriate to aged care when determining an infection. All results are analysed and trended by the infection control coordinator. Data is discussed at the staff and infection control group meetings.  The infection surveillance data sighted recorded an increase in urinary tract infections for March 2015. The quality coordinator analysed the possible cause and actions implemented to reduce the infections. Staff meetings record the actions implemented. The number of urinary tract infections was reduced in subsequent months. The staff demonstrated knowledge of infection prevention and control and strategies to reduce urinary tract infections. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Bed rails and lap belts are the approved restraints and enablers in use at the time of audit. These have been consented to by the resident or enduring power of attorney. As part of the internal auditing system, there is an annual review of restraint processes.  When enablers are used these are voluntary and the least restrictive option for the resident. All restraints and enablers are used for the safety and comfort of the resident. Restraint and enabler use is clearly identified in the resident’s file. Staff are aware of the restraint minimising strategies and ensuring enabler use is voluntary and encourages resident independence and safety. |

# 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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| 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.

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End of the report.