# Aversham House (2006) Limited - Aversham House

## 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 Health and Disability Auditing New Zealand 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:** Aversham House (2006) Limited

**Premises audited:** Aversham House

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 3 March 2016 End date: 3 March 2016

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 15

# 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

Aversham House is privately owned and operated. The service provides rest home level of care for up to 21 residents. On the day of the audit there were 15 residents.

The owner is the manager (also a registered nurse). She is supported by a part-time registered nurse and long serving staff. The residents and relatives spoke positively about the care and supports provided at Aversham House.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with family, management, staff and the nurse practitioner.

Improvements are required around notifying next of kin about incidents, incident/accidents, including pressure injuries in the quality system, resident meeting minutes, performance appraisals and job descriptions, timeliness of documentation, aspects of medicine management and review of the infection control programme.

## 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. |

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents and family interviewed spoke positively about care provided at Aversham House. Complaints processes are implemented and complaints and concerns are managed. Annual staff training reinforces a sound understanding of resident’s rights and their ability to make choices.

## Organisational management

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

Aversham House has a quality and risk management system that is being implemented. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards and repairs to the building and grounds. There is a monthly staff meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents are screened and approved prior to entry to the service. There is an admission package available prior to or on entry to the service that includes information on the services provided at Aversham House. The registered nurse is responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family. Resident files included medical notes and notes of other visiting allied health professionals.

The recreational officer provides an interesting and varied activities programme for the residents that include outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines completes annual education and medication competencies. Medication charts have photo identification and allergy status noted.

All meals are prepared on-site. Individual and special dietary needs are catered and alternative options are available for residents with dislikes. The menu has been reviewed by a dietitian.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The service has implemented policies and procedures for fire, civil defence and other emergencies. The building holds a current warrant of fitness. Rooms were individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. There was a main lounge, sunroom and separate dining room. There are adequate communal toilets and showers. Fixtures, fittings and flooring are appropriate for rest home level care. Cleaning and laundry services were well monitored through the internal auditing system. Chemicals were stored securely. The temperature of the facility was comfortable and constant and able to be adjusted in resident’s rooms to suit individual resident preference.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The service maintains a restraint free environment. There are policies and procedures to follow in the event that restraint or enablers were required. There are no residents using restraints or enablers. The registered nurse is the restraint coordinator. Staff received training around maintaining a restraint free environment, including the management of 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. |  | Some standards applicable to this service partially attained and of low risk. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse/manager) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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 | 38 | 0 | 5 | 2 | 0 | 0 |
| **Criteria** | 0 | 86 | 0 | 5 | 2 | 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 | The service has available information on the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code). Advocacy pamphlets and the Code of Rights are clearly displayed at the main facility entrance. Five residents and three relatives interviewed confirmed that information has been provided around the Code of Rights. There is a resident rights policy in place. Code of Rights training was last completed in August 2014. Discussion with two caregivers identified that they were aware of the Code of Rights and could describe the key principles. |
| 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 | Written informed consent is gained for general consents and these were sighted in the five resident files sampled. Written consent is also gained for specific procedures such as the influenza vaccine. Resuscitation orders had been signed by the resident and general practitioner in all files reviewed. Residents interviewed confirm they were given good information to be able to make informed choices. The owner/manager, registered nurse (RN) and caregivers interviewed stated the family are involved with the consent of the resident. Enduring power of attorney (EPOA) documents were sighted on the resident's files reviewed. Discussion with family identify the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code and advocacy pamphlets on entry. Resident advocates are identified on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receives education and training on the role of advocacy services. Caregivers interviewed were aware of the resident’s right to advocacy services and how to access the information. |
| 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 | The service has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. The service has a van and group outings are provided. Community groups visit the home as part of the activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the RN manager using a complaints’ book (register). There have been no complaints made in 2015 or 2016 (year to date). Residents and family members interviewed advised that they are aware of the complaints procedure. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome information folder that includes information about the Code of Rights. There is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. The RN manager/owner is available to discuss concerns or complaints with residents and families at any time. Residents and family members interviewed stated they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy. Staff signs a privacy declaration on employment. Staff attended a privacy and dignity in-service in July 2015. The RN manager/owner is the privacy officer and has an open door policy. |
| 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 | There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. The service has established a link with local iwi who provides advice for staff and advocacy for Māori. On the day of the audit there were no residents that identified as Māori. |
| 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 | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognises and responds to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services and attending other community groups as desired. Staff attended cultural awareness training in July 2014. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of a service Code of Conduct. Professional boundaries are defined in job descriptions. Staff are observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with caregivers could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The RN manager/owner is committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. All residents and families spoke positively about the care provided. The service has implemented policies and procedures from a recognised aged care consultant to provide a good level of assurance that it is adhering to relevant standards. Staff interviewed had a sound understanding of the principles of aged care and state that they feel supported by management. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Management promote an open door policy. Relatives are aware of the open door policy and confirmed on interview that the staff and management are approachable and available. Information is provided in formats suitable for the resident and their family. Six monthly resident care, family and resident food surveys are completed that provide feedback on all areas of the service. Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. Not all incident forms reviewed documented that family had been informed. The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Aversham House provides care for up to 21 rest home residents, which provides a homely environment set within spacious and attractive grounds. On the day of audit there were 15 residents. All residents were under the ARCC agreement. Aversham House is managed by a registered nurse (RN) who has owned and operated the home for the last ten years. The RN manager and husband are directors. The company is supported by an accountant for financial matters and accounts. There is an administration person on-site. The RN manager is supported by a RN who has been in the role for two and a half years and is employed for 16 hours a week. The RN manager and RN share the on call.  The business plan for 2015 has been reviewed and a 2016 business plan and goals have been developed. The plan includes quality indicators, person responsible and timeframe for implementation. The goals (including ongoing maintenance) are reviewed and signed off as completed. Goals include review of staff wages, maintaining high occupancy and improving attendance at staff meetings.  The RN manager has maintained at least eight hours annually of professional development related to managing a rest home. The RN manager has completed interRAI training. |
| 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 | During the temporary absence of the RN manager, the senior caregiver/assistant manager is the acting manager. |
| 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 Moderate | Their service has a business, quality risk assessment and management plan and this includes a quality plan. The service has in place a range of policies and procedures to support service delivery that are reviewed regularly. The service has an annual meeting schedule in place however, resident meetings have not been held as scheduled. The staff has input into the monthly staff meetings. Minutes sighted evidence there is discussion around complaints, compliments, health and safety, infection control, audit and survey results. Staff interviewed state they are well informed and receive quality and risk management information such as accident/incident and infection control stats. Implementation of corrective actions is the responsibility of RN manager. Pressure injuries are not currently included in the quality monitoring data or discussions.  There is an annual staff training programme that is implemented and based around policies and procedures. Policies have been updated to include interRAI requirements. Internal audits are completed for (but not limited to) medication, food services, resident care, cleaning service, recreation, Code of Rights, infection control and fire safety. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Resident care, resident food survey and family surveys are completed every six months. Corrective actions are in place and are completed, evaluated and signed off.  The service has implemented a health and safety management system. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. |
| 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. | PA Low | As part of risk management and health and safety framework, there is an accident/incident policy. The service collects incident and accident data and reports monthly to the staff, health and safety and infection control meetings (link 1.2.3.6). Accident/incident data, trends and corrective actions are a set agenda item on the monthly staff meeting. All incident forms are signed off by the RN or RN manager.  Ten incident forms were reviewed from January 2016 (seven falls, one soft tissue injury, one medication error and one of other category). The caregivers interviewed could discuss the incident reporting process. The RN manager collects incident, investigates and reviews, and implements corrective actions as required. However not all incident forms documented RN review and pressure injuries have not been reported as incidents (noting the incident form has now been updated to include pressure injuries). |
| 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 | There are human resources policies to support recruitment practices. The RN manager, RN’s and GP’s practising certificates are current. Five staff files were reviewed (one RN, one caregiver, one activities person, one cleaner and one cook). Not all staff files had job descriptions and annual staff appraisals in place. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes a documented checklist relevant to the area of work, health and safety induction and infection control questionnaires. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  The RN has completed a 40-hour palliative care course, infection control study day and interRAI training through external educators. There is a two yearly education plan in place. There is evidence that additional in-service opportunities are offered to staff. Interviews with caregivers, RN, activities person and cook confirm in-service education is provided on-site and externally. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The RN manager is on-site Monday to Friday. The RN is on duty two days a week (Wednesday and Thursday).  Staffing is as follows for morning shift: one caregiver 7.00am-3.00pm, one caregiver 7.00am-1.30pm and one from 7.00am-10.30am, afternoon shift: one caregiver 3.00pm- 11.00pm and one caregiver 4.00pm-9.00pm, night shift one caregiver from 11.00pm-7.00am.  There is a cleaner employed Monday to Friday mornings. The cook works from 8.00am–3.00pm Monday to Sunday. The activities person is employed for 25 hours a week Monday to Friday.  The RN manager and RN share the on call. Staff interviewed state they feel supported by the RN manager and RN who respond quickly to after-hour calls. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and resident register. Resident clinical and allied health records are integrated. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation. |
| 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 | Prior to entry, potential residents have a needs assessment completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of the service. The admission agreement reviewed aligns with a) -k) of the ARC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies to describe guidelines for death, discharge, transfer, documentation and follow up. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medication policies align with accepted guidelines. The RNs and caregivers responsible for the administration of medications have completed annual competencies and medication education. A signed medication reconciliation form evidences medications are checked on arrival by the registered nurse. Any pharmacy errors are recorded and fed back to the supplying pharmacy. There were no self-medicating residents on the day of audit. Standing orders were not in use however, signing sheets for four residents identified household remedies had been administered that were not prescribed/authorised.  Medications requiring refrigeration are stored in a sealed container in the kitchen fridge. The fridge temperature is monitored daily and is maintained between 2-8 degrees Celsius.  A weekly controlled drug stock-take is completed by the pharmacist and RN weekly on delivery of the blister packs. There is no documented evidence of weekly checks for as required controlled drug elixirs.  Ten medication charts were reviewed. All medication charts had photo identification and allergy status. Prescribing of medications met legislative requirements. A shortfall was identified around the discontinuation of medications. Not all medication charts had been reviewed three monthly by the GP. |
| 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 | All food is prepared and cooked on-site at Aversham House. There are two qualified cooks that cover the seven day week. They have completed food safety units. There is a four weekly rotating menu that has been reviewed by a dietitian. The meals are served from the kitchen directly to residents in the dining room. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated.  Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. All foods were date labelled and stored correctly. A cleaning schedule is maintained. |
| 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 | Aversham House records the reason for declining entry to residents should this occur and communicates this to residents/family/whānau and refers the resident/family/whānau back to the referral agency. The reason for declining entry would be if there were no beds available or the service could not meet the assessed level of care. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Nursing and risk assessments were completed in a timely manner using appropriate tools to meet all the resident’s needs. InterRAI assessments, assessment notes and summary were in place for three of the five resident files reviewed (link 1.3.3.3). The long-term care plans in place reflected the outcome of the assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plans describe the resident goals, supports and interventions required to meet desired goals (link 1.3.3.3) as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents/relatives confirmed on interview they are involved in the care planning and review process. There was evidence of allied health care professionals involved in the care of the resident.  Short-term care plans are used for changes in health status and evidenced to be in use in the resident files. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP/NP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident’s health status. Resident files reviewed included communication with family records.  Staff report there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. There was one skin tear and two pressure injuries of the heel (one grade III and one grade I) being treated at the time of audit. Both pressure injuries were facility acquired. Wound assessments had been completed with ongoing evaluations documented. The RN interviewed could describe the referral process to a wound specialist or continence nurse. There is evidence of GP/NP and wound nurse involvement in the wound management of the grade III pressure injury. Appropriate pressure injury prevention and interventions are documented in the care plan.  Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity, and weight loss. Caregivers interviewed confirmed they are updated of any changes in resident’s care or treatment during handover sessions at the beginning of each shift. |
| 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 service employs a recreational officer for 25 hours per week for 4 days a week. She has completed a dementia care course and has a current first aid certificate. The recreational officer attends two monthly diversional therapy meetings and on-site education. A caregiver provides activities one day per week. The activity programme is Monday to Friday.  The programme is flexible and provides a variety of activities that are meaningful to the residents. Residents have the opportunity to provide suggestions for activities and outings. Community members are involved in Tai Chi and Yoga exercises for the residents. There are regular entertainers and van outings to community events such as concerts and clubs. Residents are encouraged to maintain links with community groups such as the library, concerts and inter-home visits.  Residents attend fortnightly church services as desired on-site and are supported to attend their own church in the community.  Residents have an activity profile completed on admission. Activity plans had been reviewed at the same time as care plans. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The initial nursing assessment/care plans sighted have been evaluated by the RN within three weeks of admission. InterRAI assessments are completed six monthly or earlier due to changes in health status. Long-term care plans are reviewed at least six monthly in three of five files viewed (1.3.3.3). One resident had not been at the service six months. The GP/NP completes a three monthly resident review. The families are invited to attend the care plan review meeting. Evaluations indicate if resident goals have been met or unmet and the care plan updated to reflect the residents current health status.  Short-term care plans have been reviewed regularly by the RN and either resolved or added to the long-term care plan if the problem is ongoing. |
| 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 | The RN could describe the referral process to other medical and non-medical services. Referral documentation was maintained on resident files. The service provided an example of where a resident’s condition had changed and the resident had been reassessed from respite care to rest home level of care. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies in place for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. Chemical product use and safety data sheets are available. Chemicals are stored safely. Gloves, aprons and goggles are available for staff. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. |
| 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 service displays a current building warrant of fitness which expires on 10 June 2016. The owner/managers have a reactive and planned maintenance programme in place. Hot water temperatures checks are monitored and recorded monthly and are between 44 and 45 degrees Celsius. Medical equipment has been calibrated by an external contractor. Electrical equipment has been serviced and tagged annually.  Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access to outdoor areas. The external area is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with staff confirmed there was adequate equipment to provide safe and timely care. |
| 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 | There are two bedrooms with a full ensuite. Seven other bedrooms have a toilet and hand basin. All bedrooms have hand basins. The number of communal toilets and showers were adequate. The toilets and showers are identifiable and include vacant/in-use signs. Fixtures, fittings, floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. |
| 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 | Bedrooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. The bedroom furnishings and seating were appropriate for the resident group. |
| 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 one main lounge and a dining room located close to the kitchen. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed report they can move freely around the facility and staff assist them if required. |
| 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 | Personal clothing and sheets are laundered on-site by the care staff. All towels and handtowels are collected from the laundry external door and laundered off site. The laundry had defined clean/dirty areas and an entry and exit door. Vinyl flooring has been replaced in the laundry. The chemical provider monitors the effectiveness of laundry processes. Residents and relatives expressed satisfaction with cleaning and laundry services. There is a dedicated cleaner employed for four hours a day Monday-Friday. The cleaning trolley is stored safely when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. Civil defence supplies include 800 litres of stored water and food for 3 days. There is a barbeque and spare gas bottles. The RN manager responsible for maintenance completes emergency training for all new employees. Interviews with caregivers confirm staff are aware of emergency and security procedures. There is an approved fire evacuation plan. Fire drills have been conducted six monthly. A fire evacuation drill was last completed on 27 January 2016. There is a first aider on duty at all times.  Resident’s rooms, communal bathrooms and living areas all have call bells. The call bells ring to panels at each end of the home. Residents are orientated to the call bell system on admission to the facility. Security policies and procedures are documented and implemented by staff. |
| 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 communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed state the environment is comfortable. |
| 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. | PA Low | The infection control coordinator (RN/manager/owner) oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description for infection control and is supported by an administration assistant/senior caregiver who completes infection control documentation and graphs. Infection events are reported to staff at handovers and the staff meeting.  There is an infection control programme included in the infection control policy manual. There is no documented evidence of an annual review.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine. |
| 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 Infection control coordinator has attended external education on infection control within the last year including infection control consultant study days and online learning. The infection control coordinator have access to GPs, local Laboratory, the infection control and public health departments at the local DHB for advice and an external infection control consultant. |
| 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 control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external consultant and are reviewed regularly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule last provided June 2015. Staff have access to online self-directed learning.  Resident education is expected to occur as part of providing daily cares as appropriate. |
| 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 a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms and short-term care plans are completed for all infections. Infections are included on a monthly register and a monthly report and graphs are completed by the infection control coordinator and administrator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the management and staff meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP/NP that advises and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Aversham House has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The RN is the restraint coordinator. The restraint coordinator confirms that the service promotes a restraint-free environment. On the day of the audit there were no residents on restraints or enablers. Restraint education is included in the two yearly training programme and last occurred in June 2014. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Ten accident/incident forms were reviewed. All accidents/incidents were reported on the accident/incident form as per policy. Five of ten accident/incident forms identified the next of kin had been notified. | There was no documented evidence of notification to the next of kin for five of ten accident/incidents. | Ensure the next of kin are notified for all accidents/incidents unless requested otherwise.  90 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 Moderate | Staff and management meetings are held regularly as evidenced by meeting minutes. Residents have the opportunity to feedback on the services through resident meetings but no minutes were available for these. The quality system including the incident reports has been updated to include pressure injuries going forward. However the current pressure injuries were not included in quality data. | (i) There was no documented evidence of resident meetings between January and July 2015 and from September to December 2015. (ii) The two current pressure injuries have not been included in quality monitoring data or discussed in meetings. | (i) Ensure resident meetings are held as scheduled and recorded in meeting minutes. (ii) Ensure that all pressure injuries are included in quality monitoring data and discussed in meetings.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Ten accident/incident forms were reviewed. All accidents/incidents except pressure injuries were reported on the accident/incident form as per policy. Six of ten accident/incident forms had been signed off by the RN manager. | (i) Four of ten accident/incident forms did not evidence RN manager sign off. (ii) Two current pressure injuries were not reported as incidents. | Ensure there is RN manager sign off for all accident/incidents reported.  60 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Five staff files were reviewed. All files evidenced orientation checklists. Two of five files had signed job descriptions in place. Annual staff appraisals had not been completed in the five files reviewed. | 1) Three of five staff files had no evidence of signed job descriptions. 2) Five of five staff files reviewed did not have an annual performance appraisal. | 1) Ensure that signed job descriptions are in staff files. 2) Ensure staff performance appraisals are completed annually.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The signing sheets for regular and as required medications corresponded with the instructions on the medication chart. Regular medications were prescribed correctly. As required medications had indications for use prescribed on the medication chart. Eight of ten medication charts had been reviewed by the GP three monthly. There are no standing orders in use. The pharmacist completes a weekly stock-take of controlled drugs blister packs with the RN. Shortfalls identified around aspects of medicine management were for three monthly GP reviews of medication charts, no dating or signing of discontinued medications, use of household remedies that have not been prescribed on a standing order and no weekly checks of controlled elixirs. | 1) Two of ten medication charts had not been reviewed three monthly by the GP. 2) Household medications had been administered for four out of ten residents as sighted on the non-packaged signing sheets. There was no evidence of verbal orders or standing orders in place for the administration of panadol, laxsol, mylanta or ural sachets. The medications had not been prescribed on the resident medication charts. 3) Discontinued medications on four medication charts were not dated and signed when discontinued. 4) There were no records of weekly stock-take of as required controlled drugs (elixirs). | 1), 2) and 3). Ensure the prescribing, review and administration of medications meets legislative requirements. 4) Ensure weekly stock-take is completed for all controlled drugs.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | All resident files reviewed had initial assessments and risk assessments completed on admission. Four of the five files reviewed had an interRAI assessment and a long-term care plan in place. Three of the five files reviewed evidenced six monthly evaluations. One resident had not been at the service long enough for a six monthly and one other resident did not have six monthly evaluations of the long-term care plan. | 1) One resident admitted for permanent care does not have an interRAI assessment and long-term care plan developed within the required timeframe. 2) One resident has not had six monthly evaluations of the long-term care plan. | 1) Ensure interRAI assessments and long-term care plans are developed within 21 days of admission. 2) Ensure care plans are evaluated at least six monthly.  60 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | The infection control programme content and detail, is appropriate for the size, complexity, and degree of risk associated with the service but has not been reviewed annually. | The infection control programme has not been reviewed annually. | Ensure the infection control programme is reviewed annually.  90 days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.