# Waverley Aged Care Limited - Waverley House Rest Home

## 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 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:** Waverley Aged Care Limited

**Premises audited:** Waverley House Rest Home

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

**Dates of audit:** Start date: 21 July 2016 End date: 22 July 2016

**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:** 20

# 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

Waverley House rest home is a privately owned aged care facility. The owner/manager governs the service. Waverley House provides care to up to 20 rest home level residents with full occupancy on the days of audit.

Residents and families interviewed were very complimentary of care and support provided. The owner/manager and registered nurse are well qualified for their roles.

This unannounced surveillance audit was conducted against a sub-set of 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 residents and staff files, observations and interviews with residents, management and staff.

The service has addressed seven of eight previous findings from the certification audit relating to the quality programme, health and safety, family and resident input into care, weight monitoring, medication systems and process and ensuring a safe environment.

Further improvements are required in relation to documented interventions for care and support.

This audit identified additional improvements are required around documented registered nurse follow-up of identified resident risks.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Residents and families are kept informed on all aspects of the service and resident health. Residents and their family are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

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

An experienced owner/manager who has been in the role for eleven years, manages the service. She is supported in her role by an experienced registered nurse. Quality management processes are reflected in the businesses plan’s goals, objectives and policies. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Staff document incidents and accidents.

Residents receive appropriate services from suitably qualified staff. Recruitment is managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place for new staff with ongoing education and training provided.

## 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. |

InterRAI assessments are being implemented and paper based assessment tools are used on admission and thereafter. Assessments, care plans and care plan evaluations are completed by registered nurses. A diversional therapist plans and implements the activity programme. There are outings into the community and visiting entertainers. The medication system meets legislative requirements. The service uses a paper-based medication management system. All meals are prepared and cooked onsite. Resident’s individual dietary needs were identified and accommodated.

## 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. |

A current building warrant of fitness is displayed which expires 16 November 2016.

## Restraint minimisation and safe practice

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

There are documented and implemented policies and procedures around restraint use and use of enablers. There were no residents with restraint or enablers at the time of audit. The service operates environmental restraint as the main door egress is operated by a code. All five files reviewed documented a consent for this. Restraint audits, training and competencies for staff have been completed.

## 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 control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) monitors infection rates. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training on infection control. No outbreaks have been recorded.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 17 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 44 | 0 | 1 | 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 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Click here to enter text |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. The manager and the RN operate an ‘open door’ policy. Residents and relatives confirmed they are aware of the complaints process. Staff interviewed (the manager, the RN, the diversional therapist and four caregivers) were able to describe the process around reporting complaints.There have been no complaints for 2016.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy in place. Residents are provided with a range of information on admission regarding the scope of service and any items they have to pay for that is not covered by the agreement. An interpreter is provided as required. Regular contact is maintained with family including if an incident or care/health issue arises. Relatives sign a communication sheet to inform the service when and under what circumstances they would like to be informed. Three relatives and three residents agreed that the service maintains a high level of communication. Nine of nine resident related incident forms reviewed for June 2016 identified family were notified. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Staff communication was observed to be very good with residents with poor hearing and cognitive deficits.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waverley House is privately owned by the manager. The service provides care for up to 20 residents at rest home level care. On the day of the audit, there were 20 residents in total. All residents are on the age related contract.The manager is non-clinical and has had twenty years aged care experience. She has been the manager of Waverley House for the past 11 years. An RN supports the manager. The RN was previously employed as a long-serving caregiver prior to commencing nursing studies. She graduated with a Bachelor of Nursing in December 2014. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home including attendance at provider meetings, cultural awareness and dementia care. The service has purchased a new quality system including polices procedures, training, audits and associated documentation. This system is in the process of implementation. There is a 2016 business plan, quality and risk plan developed which aligns with purpose, mission and values of the business. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan is in place. The new quality system includes comprehensive policies and procedures. There is a documented process for the implementation of new policies and procedures, which includes information at staff meetings, and a signing process for staff to document when they have read polices. Staff meetings review all document policies being rolled out each month.There is a 2016 risk plan, a quality plan, and business plan. Monitoring of the quality and risk plan is through the monthly quality/staff meetings and reports. The quality and staff meetings document discussion and follow-up of quality data, incidents and accidents, health and safety, infection control, complaints (where they occur) and restraint (as needed). There are a series of quality improvement plans in place including new care plan templates being implemented and the new quality process and forms.The service completes internal audits as per the annual audit programme. Corrective actions have been developed for all opportunities for improvements identified through quality activities. Health and safety discussion and quality data is incorporated into the monthly quality/staff meetings. There is a specific health and safety agenda item. Staff complete hazard identification forms for identified/potential hazards. A current hazard register is in place. The service has addressed the previous findings relating to reporting of quality data to staff meetings, maintaining an up-to-date hazard register and the completion of hazard forms.  |
| 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 | The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and a report documented for the monthly quality staff meeting. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of nine resident related incident reports for June 2016 was reviewed. All incident forms documented RN review and follow-up. Two residents with high falls were followed up. The care plans had not been updated with the change of care need (link to 1.3.3.4 and 1.3.5.2). Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. |
| 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 | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The registered nurse has a current practising certificate. Six staff files were reviewed (the registered nurse, four caregivers and one diversional therapist). Evidence of signed employment contracts, job descriptions, orientation and training were in the files reviewed. Annual performance appraisals have been conducted for all staff as they fall due. Newly appointed staff complete an orientation that is specific to their job description. Care staff interviewed described the orientation programme that includes a period of supervision. The service has an annual training schedule for in-service education. The education has been implemented and attendance recorded. Staff complete competencies relevant to their roles. The registered nurse is trained and competent in the use of the InterRAI assessment tool. The registered nurse and senior caregivers all have a first aid certificate and medication competency. This ensures that there is at least one staff member on all shifts with a first aid certificate and a current medication competency.  |
| 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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The registered nurse is on-site from 9am to 2pm during weekdays and on-call after hours and on weekends. A qualified DT is employed for 18 hours per week. A home assistant is employed seven days per week for laundry and cleaning.  |
| 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 | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks the medication roll on delivery against the medication charts and any pharmacy errors recorded and fed back to the supplying pharmacy. Paper-based medication charts were clear and easy to read.The registered nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. There were no self-medicating residents on the day of audit. The medication fridge has temperatures recorded daily and these are within acceptable ranges. Ten medication charts were reviewed. Photo identification and allergy status was on all ten charts. Nine of ten medication charts had been reviewed by the GP at least three monthly (one was new). The medication round was observed and a safe and correct process was in place.Previous findings around safety of the medication keys, medication fridge temperatures, medication round process, indications for ‘as needed’ (PRN) medications, three monthly GP reviews and medication competencies for staff have all been rectified.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Waverley House continue to be prepared and cooked on site. There is a four weekly seasonal menu that a dietitian has developed and reviewed. The cook interviewed is aware of resident dietary needs and notified of any changes. Resident likes and dislikes are accommodated. Cultural and religious food preferences are met. Specialised utensils and crockery are available for use to promote resident independence with meals. Residents interviewed state alternatives are offered for dislikes and expressed satisfaction with the meals. Caregivers were observed encouraging a range of residents to eat. Staff were observed to offer a range of different meals and snacks to residents. Progress notes all documented meal monitoring. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are taken on the midday meal. Cleaning schedules are maintained. Chemicals are stored safely. Staff were observed to be wearing correct personal protective clothing. All food services staff have completed training in food safety, hygiene, and chemical safety.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Waverley House is implementing a new care plan format. Of the five care plans reviewed, one resident was admitted within the past 21 days, two longer-term residents had the new template and two had the older template. The new resident had a comprehensive initial care plan in place. Not all resident long-term care plans provided adequate information and demonstrated service integration and input from allied health. These care plans documented clear direction to staff. Not all files reviewed had all care interventions documented in the care plans. The previous audit finding remains. The previous audit finding around resident and family input into care has been rectified. All five care plans had been signed by either the resident or a family member. Residents and family interviewed all agreed that the service involves them in all aspects of care and support. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Family members agreed that care is provided consistent with their resident’s needs and that they were involved in the care planning. Care staff interviewed stated that there is adequate equipment provided including continence and wound care supplies and they were well informed regarding resident care needs. The service had no residents with wounds on the day of audit. There are templates available to wound assessment, wound management and evaluation forms. Pressure injury prevention equipment was available, such as pressure relieving devices, turning charts, audits, education for staff and policies and procedures specific to pressure injury prevention. Access to specialist advice and support is available as needed. The previous audit finding around weight monitoring has been rectified with all four longer-term resident files documenting at least monthly weights. The new resident had their weight documented on admission to the service. |
| Standard 1.3.7: Planned ActivitiesWhere 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 continues to employ a qualified diversional therapist (DT) to coordinate and implement activities for the rest home residents.The programme offers variety and interest with entertainment and outings. Residents were able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. The activity plan reflects the resident’s individual recreational and social needs, covers a variety of activities such as supervised walking in small groups for those consumers who enjoy walking, quizzes, bingo, outings, exercises, crafts, entertainment, music, other board games and games suitable for indoors and newspaper reading. Activities are planned monthly. A copy of the activities plan for each week is displayed on the notice board at the reception/entrance area and in the lounge. Individual activities are provided for residents who do not wish to participate in the group programme. Activity assessments were completed on admission in the resident files sampled, individual activity plans are evaluated monthly. The three monthly resident meetings and six monthly resident satisfaction surveys provide residents an opportunity to feedback on the activity programme.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans are evaluated at least six monthly or earlier if there is a change in health status.  Six monthly reassessments have been completed using the InterRAI LTCF for all residents who have been admitted over six months.  Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing.  Where progress is different from expected, the service responds by initiating changes to the care plan. |
| 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 | The service has policies around chemical/substance safety and waste management. Management of waste and hazardous substances is covered during orientation of new staff. Chemicals are stored safely in a locked cupboard. Safety datasheets and product wall charts are available. All chemicals were labelled correctly. Approved sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons, and goggles are available for staff at the point of use. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. Staff have attended chemical safety training with the approved provider for chemicals (May 2016). The previous audit findings have now been addressed.  |
| 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 16 November 2016.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection monitoring is the responsibility of the infection control coordinator (registered nurse). The infection control policy describes routine monthly infection surveillance and reporting. Monthly surveillance activities are appropriate to the acuity, risk and needs of the residents. Monthly infection data is collected for all infections based on signs and symptoms of infection. Infection control is discussed at staff/quality meetings and staff handovers. There have been no outbreaks reported since the previous audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There are policies around the use of restraints and enablers, which align with the standard. The registered nurse is the restraint coordinator. There were no residents using restraint or enablers at the time of audit. Staff have received training around restraint minimisation, the management of challenging behaviour and completed restraint competencies. Enablers are voluntary. The service operates environmental restraint. Egress through the front door is via a code pad. The door opens on activation of the fire alarm. All five files reviewed included a consent form for the environmental restraint. |

# 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 1.3.3.4The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Caregivers, the registered nurse and the manager where able to describe a comprehensive handover between shifts, and handover was observed on the day of audit. Caregivers interviewed were all able to describe the care and support needed for residents in their care. Three of five resident progress notes evidenced that care issues identified by caregivers, have been followed up by the RN.  | Two resident’s progress notes included issues noted by caregivers that had not been documented as followed up by a registered nurse.  | Ensure that issues raised by caregivers though progress notes are documented as followed up by the registered nurse.60 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The service continues to implement a new care plan template. New care plans include sections such as pressure injury care, skin care and falls management. Not all care interventions were documented in care plans. .  | i) Two care plans did not address the falls risks identified from recent incident forms. ii) Two care plans did not include updated basic nursing care needs where the resident had increased needs. iii) One resident on warfarin did not have the risks associated with warfarin recorded in the care plan (noting all caregiving staff have had education on risks related to warfarin).  | i) Ensure that risks identified in incident forms are addressed in care plans. ii and iii) Ensure that care plan interventions address all assessed risk and identified problems. .60 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.