# Ambridge Rose Manor Limited - Ambridge Rose Manor

## 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 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:** Ambridge Rose Manor Limited

**Premises audited:** Ambridge Rose Manor

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

**Dates of audit:** Start date: 1 March 2017 End date: 2 March 2017

**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:** 102

# 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

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board (DHB). Ambridge Rose Manor provides rest home and hospital level care for up to 104 residents. There have been no changes to the organisation of the facility since the last audit.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family, management, staff and the general practitioner.

The organisation achieved full compliance to all requirements of this audit. One continuous improvement rating has been allocated.

## 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. |

Staff are able to demonstrate an understanding of residents' rights. This knowledge is incorporated into their daily work duties. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained.

There is a transparent and well implemented complaints management process. A complaints register is maintained and complaints/concerns are viewed as an opportunity for improvement.

## Organisational management

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

The organisation is governed by the directors/owners. Day to day operations at the facility is the responsibility of the chief executive officer (CEO), and the chief operations officer (COO). Organisational performance is monitored. The mission and strategic goals are documented and reviewed.

Quality and risk management systems support service delivery. Achievement towards quality goals is measured. Internal audits are conducted. Collated quality and risk data is providing full analysis on trends and themes. The required policies and procedures are documented, reviewed and controlled. Quality activities are monitored and communicated throughout the organisation.

Human resource process support good employment practice. All staff receive an orientation. Ongoing training is provided and staff competencies are assessed and monitored. There is adequate numbers of skilled staff on duty at all times.

Resident records are maintained in both electronic and hard copies. Records are integrated and maintained in a secure manner. Entries in records meet best practice standards for the management of health records.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

The registered nurses are responsible for the development of care plans with input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities. Residents expressed satisfaction with the activities programme in place.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## 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 facility was purpose built and has a current building warrant of fitness. Ongoing maintenance and compliance monitoring ensures that the physical environment meets the needs of the residents and health and safety requirements. Electrical and medical equipment, furniture and fittings are maintained in safe working order.

All residents have private bedrooms. There are sufficient communal areas within the facility, and the garden, for residents to enjoy. Outdoor areas are maintained to ensure safety.

There are documented cleaning and laundry procedures. Personal protective equipment is readily available. Appropriate training, information, and equipment for responding to emergencies are provided. Cleaning and laundry services monitored.

There is an approved evacuation plan and fire drills are conducted as required. Emergency management plans and equipment are in place.

## 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 is a designated restraint coordinator and restraint committee. The use of restraint is minimised. Enablers are used on a voluntary basis. All restraint and enabler use is assessed, approved and monitored. Staff receive sufficient education and maintain their competencies. Policies and procedures on restraint and enabler use are current.

## 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 management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinators are responsible for coordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

## 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 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 | Policies reflect the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed demonstrated their knowledge of the Code. The Code is included in staff orientation and in the annual in-service education programme. Residents and relatives interviewed, and observation during the audit, indicated that staff understand resident rights and their responsibilities and that resident rights are observed in practice. |
| 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 | Policies and procedures on consent support the residents right to make informed decisions, having heard all options in a form they understand and to have consent obtained before any health teaching or health research; or collection and use of information for administrative or epidemiological purpose; or procedures and treatment; is commenced and carried out. The resident also has the right to refuse treatment and/or medication, in the clear knowledge of the possible medical consequences if such is refused. The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives.  The residents' files sampled had the required consent forms signed by the resident, or when appropriate, signed by the enduring power of attorney (EPOA). The files contained copies of any advance care planning and the resident’s wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them. Residents interviewed confirmed that they were provided with day to day choices and consent was obtained. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff training on the right to advocacy / support is provided annually. |
| 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 | There are no set visiting hours and relatives are encouraged to visit at any time. Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Information about the complaints process is provided to residents/family on admission. The process and forms are readily available. The resident's right to complain is discussed with the resident and family. Interviews with residents and family confirmed awareness of their right to make complaints if they wish.  The complaints register and associated records indicate effective and timely handling of complaints in accord with Right 10 of The Code. Verbal concerns are discussed with management and at residents’ meetings. Written complaints are added to the complaints register. The register includes the date, nature of complaint, action taken and resolution.  There have been three formal complaints forwarded to the Health and Disability Commissioner since the last certification audit. Related records were sampled. Two of the three complaints have been fully investigated and found that Ambridge Rose had no case to answer. The remaining complaint is still under investigation. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information about the Code, advocacy services and the complaints process is provided on admission and displayed in the entry foyer. Residents and families interviewed were aware of their rights and confirmed that information was provided to them during the admission process. The Ambridge Rose information pack is available in residents’ rooms. Signed residents’ agreements were sighted in records sampled. Service agreements meet the requirements of this standard and district health board requirements. |
| 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 privacy and dignity policy details how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents’ related information. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting resident’s individual beliefs and values. All rooms are single occupancy, which maintain physical, visual and auditory privacy. Personal property is maintained in a secure manner.  Policies and procedures on abuse and neglect include definitions and reporting requirements. All staff receive training on the identification and reporting of concerns. There were no complaints or adverse events regarding alleged abuse or neglect. |
| 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 | The Maori perspective on health is documented and includes Maori models of health and barriers to access. Terminal care and death of the Maori resident is included. Cultural needs are included in the care plans (if identified). There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. The organisation maintains contact and input from a local kaumatua. Cultural safety training is provided to all staff. The Code is available in Maori and satisfaction surveys include cultural and spiritual beliefs. |
| 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 | Cultural needs are determined on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident. Values and beliefs are discussed and incorporated into the care plan. Residents and family members interviewed confirmed they are encouraged to be involved in the development of the long term care plan. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies define processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct, house rules and professional behaviour is included in the employment and orientation process. Staff receive information and education regarding non-discriminatory attitudes and behaviours.  Interviews with residents and family, and observation during the audit, indicated that residents are free of any form of coercion or discrimination. In interview, the general practitioner (GP) confirmed the provision of consistent and respectful care to all residents.  Management representatives stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Good practice is maintained, encouraged and monitored. Staff reported that they were satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence based practice. There are regular visits by the GP and allied health providers as required. The CEO is actively involved in the aged care sector and is up to date with Ministry of Health and DHB incentives, policy and trends. The clinical team is additional to the roster which ensures that all staff have access to clinical support. The organisation is innovative with the use of systems and data which enables close monitoring and clinical indicators and supports continuous improvement (refer standard 1.2.3). |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Staff education is provided related to appropriate communication methods. The service has required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documenting of open disclosure following incidents/accidents was evident. Families reported they are informed of any events or concerns. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation is governed by two directors/owners, one of whom is the chief operating officer (CEO). The directors also own another age care facility in the area. The strategic direction of the organisation has recently been reviewed. Goals and company objectives are defined in measureable terms.  Organisational performance is monitored in an ongoing manner. The organisation chart defines reporting lines throughout the organisation. The chief operating officer (COO) and the quality manager report directly to the CEO and directors. Operational management reports sampled confirmed organisation performance and monitoring of achievement towards the strategic goals.  Day to day management is the responsibility of the CEO and the COO. The COO is supported by the management team which consists of the quality manager and the clinical manager. The management team meets monthly. All members of the management team are suitably qualified and maintain professional qualifications in management, finance and clinical skills.  The organisation provides 104 beds. All beds can accommodate residents who have been assessed as requiring rest home or hospital level care. The organisation also has a contract to provide respite services and long term support for chronic health conditions through the DHB. At the time of the audit there were 15 rest home residents (one of whom was accessing the respite service) and 87 hospital residents (two of which were under the long term chronic contract). There were no residents under the aged of 65 years old. |
| 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 | Succession planning is a component of the strategic planning process. The COO is able to cover CEO duties during a temporary absence. The COO’s position description defines the succession planning process. The CEO and COO are both on call 24 hours a day, seven days per week.  There are four members of the clinical management team. This includes the clinical manager, registered nurse supervisor, clinical co-ordinator and clinical support. The clinical team are additional to the roster and are able to cover absence for any member of the team. |
| 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 framework is documented and implemented. This includes a description of quality goals and quality related activities. Staff receive an induction to quality activities during the orientation process.  Organisational policies and procedures are purchased from an external contractor. Policies reflect standards, contracts, good practice, legislation requirements and are readily available to staff. All policies are subject to reviews and all policies sampled were controlled documents. Obsolete documents are archived and staff are alerted to changes as they occur. Changes were made to the some of the procedures following recommendations made during the pre-audit process.  A range of quality related activities are conducted. Service delivery is monitored through complaints, surveys, health and safety, review of adverse events, surveillance of infections and implementation of an internal audit programme. The electronic data base provides a wide variety of reports and enables close monitoring and analysis of specified/chosen data.  There is a documented and fully implemented internal audit programme. This covers the scope of the quality system. There is evidence that any area of non-conformance is remedied and followed up. The results of internal audits are discussed at management and staff meetings. Internal audits are viewed by the COO. In addition a number of quality initiatives are developed, implemented and evaluated. This has resulted in a continuous improvement rating.  A risk management programme is in place. A risk matrix is documented. This includes health and safety processes and hazard management. There is evidence that business, environmental, clinical and financial risks are monitored and discussed at operational management team meetings. |
| 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 | Management interviewed were aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks and missing persons. This was confirmed in adverse event records sampled where notifications, including a Section 31 notice to the Ministry of Health, were required.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff receive education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.  All adverse events are documented using the electronic data base. A range of incident reports were sampled. Each incident report had a corresponding note in the progress notes to inform staff of the incident. There is evidence of follow up with the GP and family members.  The data base provides alerts which ensure all incidents are followed up and closed out in a timely manner. A full analysis of incidents is reported at management meetings. This includes discussions regarding any required improvements to the system. |
| 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 is a defined and implemented recruitment process. References are gained and qualifications are validated, including those required by external providers. Employment contracts and position descriptions were sighted in all staff files sampled.  All staff have an orientation which includes the essential components of service delivery. This includes training on emergency management. Staff who administer medications have the required competency assessments and a sufficient number of staff have a current first aid certificate. There are four registered nurses who are able to complete interRAI assessments.  An in-service training plan is developed every two years. In-service education is held monthly, as per the training plan. Education and training hours exceeded eight hours a year for each staff member and include the required topics. Individual training records are maintained. Attendance at staff training is monitored by the quality manager. In interview, staff confirmed they have access to sufficient training opportunities.  Staff performance is monitored, and annual performance appraisals were sighted in records sampled. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Rosters and duty lists are documented. Staffing levels are sufficient in number and take into consideration the layout of the building. There are two registered nurses on duty during the day and one at night. Additional registered nurses are available on call if required. The clinical manager is on site Sunday to Thursday and a registered nurse supervisor is rostered Tuesday to Saturday. There are a total of 65 health care assistants. Health care assistants are rostered over the 24 hour period, with three on during the day and one at night in each wing. Rostered sampled confirmed that full cover is provided; this includes during a time of absence. Bureau staff are available, but very rarely required. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The admission process provides verification and documentation of individual resident information. Daily resident lists are maintained in the electronic client management system. Access to electronic records is guarded by individual password. The organisation has their own server and electronic data is backed up nightly and held securely off site on external hard drives.  Hard copy of resident information is stored securely in the nurses’ stations. Review of residents’ records indicated they include reports from all health professionals. Daily progress notes are maintained and records are integrated between hard copy and electronic mediums. Entries are legible, dated, signed and designated. A specimen signature list is maintained.  Archived records are stored for 10 years. Archived records are maintained in a secure and safe manner. |
| 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 | The entry to service policy includes all the required aspects on the management of enquiries and entry. Ambridge Rose Manor’s welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whanau of choice where appropriate, local communities and referral agencies.  Records sampled confirmed that admission requirements are conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident’s records to confirm this. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner and medication entries sampled on the electronic system complied with legislation, protocols and guidelines. Medications are stored in a safe and secure way in the treatment rooms and locked cupboards. The e-prescribing electronic system is accessed by use of individual passwords and generic facility log in. Medication reconciliation is conducted by the RNs when the resident is transferred back to service. The organisation uses the electronic system for e-prescribing, ordering, dispensing and administration. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos uploaded for easy identification.  An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RNs were observed administering controlled medications and an enrolled nurse (who has been assessed as competent to give medication) was observed administering medication correctly.  The controlled drug register is current and correct. Weekly and six monthly stock takes are conducted and all medications are stored appropriately.  There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Meal services are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. The resident’s weight is monitored regularly and supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. |
| 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 | The nurses and the admission coordinator reported that all consumers who were declined entry are recorded on the pre-enquiry form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. |
| 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 documented interventions in short term care plans and long term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Electronic progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies are observed and the staff confirmed they have access to the supplies and products they needed. |
| 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 planned activities are meaningful to the residents. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The activities staff reported that they modify activities based on the residents’ responses and interests and also according to the capability and cognitive abilities of the residents.  The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short term problem has resolved. |
| 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 | There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP. |
| 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 documented processes for handling waste and hazardous substances. Processes for the collection, storage and disposal of biomedical waste, single use items, household rubbish and recyclables are in accord with infection control principles and comply with local body requirements. A hazardous substances register is maintained.  Staff receive training in the handling of chemicals and hazardous waste. Chemicals are delivered by an external provider. Chemicals are accessed through a closed chemical dispensing system. Secure storage is provided. Safety data sheets are available in the laundry and cleaner's cupboard. Personal protective equipment is provided and observed to be used by staff. |
| 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 facility was purpose built in stages over a number of years, as bed numbers increased. Resident areas cover two floors with three separate wings. There are safe external areas with an enclosed garden. Well-furnished lounge and dining areas are provided. Handrails are in all corridors. Ramps have non-slip floor covering and handrails. There is sufficient space for the use and storage of mobility aids.  The current building warrant of fitness was sighted. On-going checks on the environment are conducted to ensure it remains safe and compliant. This includes monthly inspections of security, fire safety systems, call bells and emergency lighting. A maintenance person is employed and there is evidence that any maintenance issues are addressed in a timely manner.  Equipment is maintained in safe working order. Medical equipment is calibrated as required and electrical equipment has the required electrical checks. An equipment register is maintained which ensures that all equipment is checked on the due date. The required equipment is available as required to maintain the safe and comfort needs of the residents, for example reclining chairs, hoists and electric beds. These were all sighted to be in good working order.  Residents/family satisfaction surveys and interviews confirmed general satisfaction with the environment. |
| 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 is a combination and bathing, showering and toilet facilities throughout. This includes private ensuites and shared bathrooms. All facilities are located in a manner that is easily accessible and identifiable. Floors and surfaces are consistent with infection control requirements. Hot water temperatures are monitored to ensure that the water remains at a safe and consistent temperature. Visitor toilets are available throughout the facility. |
| 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 | All residents have a private room. Bedrooms provide sufficient space for movement, equipment and personal items. Electric beds are maintained in good working order and pressure mattresses and bed rails are provided for those who have been assessed as requiring them. Each bed space is provided with a nurse call bell. |
| 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 | Each wing has a communal area which is utilised for activities, lounging and meals. Furniture is suitable and well maintained. Recliner chairs are available in each area for those who require them for comfort and safety. A large number of residents come to the table for meals. Communal areas are sufficient to accommodate all the residents. There is a variety of seating to suit all needs. |
| 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 | Laundry services are provided on site. The laundry has separation of clean and dirty areas and laundry processes meet good practice guidelines. Maintenance, functional testing and temperature records indicate that laundry processes meet infection control standards and laundry audits completed demonstrate that corrective actions are completed as required.  Cleaning services are provided by employed staff. Review of internal audit records and visual inspection indicate that cleaning meets infection control requirements and is of a good standard. Well-equipped cleaning trollies with secure storage for chemical containers are provided. Cleaning staff are trained in the use of equipment and chemicals. Material safety data sheets are available in work areas.  Management monitors cleanliness standards through observations, resident/family feedback and internal audits. Interviews with staff, residents and family indicate satisfaction with facility cleanliness. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved evacuation scheme. There is evidence in staff training records that fire and evacuation training is conducted regularly as required. Staff attendance at evacuation training is monitored.  There are sufficient supplies in the event of a civil defence emergency. All staff are trained in emergencies and all registered nurses (and some health care assistants) have current first aid certificates. Emergency supplies, including water, are regularly checked. Back up emergency lighting is available. All bed spaces, bathrooms and toilets have a nurse call bell. These were seen to be within easy reach of the resident.  A suitable security policy and lock down process is in place. Staff have swipe cards to access different areas of the facility. The main gate closes in the evening; however there is an intercom system in the event of entry after hours. There are security stays on all the windows.  Satisfaction surveys include questions regarding security and safety. Surveys sampled confirmed that resident feel safe at all times. |
| 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 | The facility has plenty of natural light. All bedrooms have at least one good sized window. There is plenty of natural ventilation. The facility is maintained at a consistent temperature with heating in each bedroom. Observations during the audit and interview with residents and family members indicated that the internal environment is maintained at a comfortable temperature. The facility is smoke free. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Ambridge Rose Manor provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical manager and quality manager are the infection control coordinators (ICCs) and have access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICCs including role and responsibilities is in place.  The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.  There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| 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 ICCs are responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICCs have access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| 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 organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control is conducted by ICCs and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources include: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| 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 | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation policy. This includes methods for minimising restraint and approved alternatives. Definitions of restraint and enablers are consistent with this standard. Records sampled confirm that staff actively work to minimise the use of restraint. Goals for minimising the use of restraint are discussed at operational management team meetings.  All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process. On-going education is provided.  There are currently 22 residents who are using enablers for safety and comfort. These are used on a voluntary basis and include bed rails, recliner chairs and lap belts.  The assessment, approval, monitoring and review process is the same for both restraints and enablers. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is a registered nurse. The coordinator is supported by the quality manager regarding restraint practice and quality and risk considerations. The role of the coordinator is documented. The use of all restraints and enablers is provided in reports to the operational management team.  The use of restraint must be approved by the clinical team, including the family and GP. The approval process is comprehensive and requires a full assessment of risk and evidence of trialled alternatives. The required approvals were sighted in restraint records sampled.  Approved equipment which can be used as a restraint includes low beds, bed rails, lap belts and recliner chairs. There are currently five residents who have been assessed and approved to have a restraint in use. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint assessment process is fully documented and includes the requirements of this standard. Resident records sampled confirmed completed assessments and approvals. Assessments and approvals were signed by the resident (or family), the GP and the restraint coordinator. The assessment identified the cause, alternatives, risk, cultural considerations and outcomes. The most common reason for implementing a restraint in the records samples was for safety reasons. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | All restraints are used as a last resort. Discussions regarding trialled alternatives were sighted in records sampled. Once in place, restraints are monitored for safety. Bed rails have protective covers and recliner chairs are situated in the communal areas for frequent observing. All residents on a restraint are monitored every two hours. The restraint coordinator maintains a log of all restraint use, including evidence of two hourly checks. It was the successful use of this log that resulted in the quality initiative mentioned in standard 2.3. There have been no reported incidents related to unsafe restraint use. Restraints were observed to be in safe use during the audit. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is evaluated during the care plan review process. In the event it is considered that the resident may be able to have the restraint discontinued the process is to remove the restraint and monitor the resident hourly for a number of days to ensure on going safety. The family and GP are first notified and approval obtained. Evidence of the safe and timely discontinuation of a restraint was sighted in resident records sampled. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint reports for the month are collated and reported at operational management meetings. These reports include trends and any adverse/untoward events. For example the number of residents requiring a restraint decreased in November 2016. The highest number of restraints was noted during the month of July 2016 and a rational was documented.  Compliance with the restraint policy and procedure is closely monitored by the quality manager, who conducts routine internal audits on the process. In the event a variance in process, or gap in staff knowledge is identified, and quality initiative is developed. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | CI | All data is analysed for trends and used to continually improve services and outcomes. For example: it was noted that there had been a higher than expected level of medication errors when administration times fell outside the normal regime. A quality initiative was developed which resulted in the addition of a new system. Following implementation of the system an evaluation was completed which confirmed that medication errors have been trending down over the last three months.  Another quality improvement was conducted to reduce/prevent grade four pressure injuries. Data collection commenced in May 2015. An additional activity for assessing, grading and monitoring pressure injuries was implemented. Results were evaluated with an additional internal audit conducted in February 2016 which confirmed a decrease in pressure injuries by one third.  A quality initiative on restraint monitoring was conducted following an internal audit where it was noted that two hourly monitoring was not consistent during the busiest time of the day. A new system was implemented which included additional activities and reporting. Care rosters and the hand over process were improved. Quantitative data was collected from March 2016 to December 2016 and has resulted in a decrease (from 24 to one) episodes of non-compliance to the current process. | Quality initiatives demonstrate continuous improvements are made resulting in improved outcomes for residents. |

End of the report.