# KVTN Investments Limited

## Introduction

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

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** KVTN Investments Limited

**Premises audited:** Alexandra Rest Home

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

**Dates of audit:** Start date: 8 March 2017 End date: 8 March 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:** 41

# 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

Alexandra Rest Home is certified to provide rest home level care for up to 45 residents. There have been no changes to governance or management since the last certification audit.

This surveillance audit was conducted to assess on going compliance with the Health and Disability Standards and the contract with the district health board (DHB). The audit process included a review of policies and procedures, sampling of both resident and staff files, observations, interviews with residents, family, management, governance representatives, staff and a general practitioner (GP).

The previous area of non-conformance regarding self-administration of medication has been addressed. There were no areas of non-conformance identified during the audit. Continuous improvement ratings have been allocated regarding quality activities, internal audits and the corrective action process.

## Consumer rights

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

Residents and family report that they are given sufficient information and feel informed. Management has an open door policy. Information regarding the services available is provided and resident satisfactions surveys are conducted. There is evidence that family are notified as required. The complaints process is accessible and a complaints register is maintained. There is evidence that complaints are used as an opportunity to improve.

## Organisational management

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

There is a documented and implemented quality and risk management system. The required policies and procedures are documented and current. Organisational performance is monitored. Quality activities and initiatives ensure that improvements are made in a manner which demonstrates continuous improvement. Adverse events are well managed and monitored for trends. Human resource processes ensure that there are a suitable number of trained staff on duty at all times. Staff numbers are sufficient to ensure the needs of residents are met over the 24 hour period.

## Continuum of service delivery

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

Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and evaluated in a timely manner. Interventions are sufficiently detailed to address the care needs. Short term care plans are developed when acute conditions are identified and resolutions are documented.

Planned activities are appropriate to the needs, age and culture of the residents who reported that activities are enjoyable and meaningful to them.

The medicine management system meets the required regulations and guidelines. Medication competencies are maintained.

Food services meet food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met.

## Safe and appropriate environment

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

There is a current building warrant of fitness and there have been no changes to the facility since the last certification audit.

## Restraint minimisation and safe practice

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

Policies and procedures identify the safe use of restraints and enablers. There were no restraints or enablers in use at the time of the audit. All staff receive training on the use of restraints and enablers.

## Infection prevention and control

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

Infection control surveillance activities are appropriate to the size and scope of the service.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 1 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 35 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Complaints policies and procedures are compliant with Right 10 of the Code. The owner/manager is responsible for the management of complaints. A complaints register is maintained. There have been two formal complaints since the last audit. Complaint records sampled confirmed that these were well management and linked to the quality and risk management system.Residents and their family are advised on entry to the facility of the complaint processes and the Code. The complaints process is readily accessible and/or displayed. Residents and family members interviewed were aware of the complaints process. There have been no investigations by the Ministry of Health, Health and Disability Commissioner or District Health Board since the previous audit. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is evidence of open and transparent communication between residents/relatives, staff and management. A review of adverse events confirmed timely and open communication with residents/family members. Communication with family members is recorded in the progress notes. Family members expressed satisfaction with how well they were kept informed about any change to the resident’s condition and their involvement in resident care planning. Resident meetings are held three monthly and minutes were reviewed. The owner/manager advised that interpreter services are able to be accessed from the interpreter services, if required. This information is also provided to residents/families as part of the information/admission pack. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The facility is managed by the two owners/managers. An organisational chart shows the responsibilities of each owner/manager along with reporting lines for key positions. The facility managers maintain the required knowledge and education and are members of the New Zealand Aged Care Association. Management is supported by the care manager who is an experienced registered nurse. The care manager was appointed in 2016 and the required notification was made to the Ministry of Health.The current business plan includes strengths and weaknesses analysis, the purpose, scope, direction and goals. Goals are documented in measurable terms. There are also documented values, mission statement and a philosophy of care. There were 41 residents assessed as requiring rest home level care on the day of the audit. KVTN Investments Limited has contracts with the district health board to provide aged related residential care (rest home); long term support – chronic health conditions and short term residential care. There was one resident under the aged of 65 years. |
| 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. | CI | There is a documented quality and risk management system. The required policies and procedures are documented and reviewed as required. Procedures are controlled and reflect current best practice and legislative requirements. Master copies are maintained and obsolete documents are removed from circulation.Organisation performance is monitored through a combination of quality activities, initiatives and reports. The internal audit programme provides management with confidence of ongoing compliance and quality improvements are evaluated in a continuous improvement model. Resident and family satisfaction surveys indicate that residents and families are highly satisfied with the services provided. Quality data is discussed at monthly quality assurance meetings. Records of meetings sampled confirmed discussions and analysis of trends, including clinical indicators. There is a designated quality assurance officer.A risk management plan is documented. This covers the scope of the organisation and is reviewed as required. A health and safety programme is in place.  |
| 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 | Adverse events are documented as per policy requirements. Accident and incident forms are reviewed by the facility managers and care manager and signed off when completed. Corrective action plans to address areas requiring improvement are documented. The care manager and registered nurse undertake assessments of residents following an accident and immediate actions are implemented as required. Staff confirmed they are made aware of their responsibilities for completion of adverse events and the owner/manager is aware of essential notification requirements. The quality coordinator collates all incidents and accidents and provides the quality assurance team with detailed reports. Records of adverse events sampled confirmed open disclosure and communication with family and GP as required. Progress notes provided full details of immediate actions and follows up. |
| 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 | Policies and procedures on human resources are in line with good employment practice. The skills and knowledge required for each position is documented in position descriptions which outline accountability, responsibilities and authority. These were sighted on staff files along with employment agreements, reference checks, and police vetting and completed orientations. Current copies of annual practising certificates were sighted.The owners/managers and the care manager are responsible for the in-service education programme. The education planner for 2016-2017 was sighted and includes the required topics as per the contract with the DHB. The organisation has an agreement with another aged care provider for the provision of ongoing education. Individual staff attendance records are maintained. Competency assessment questionnaires are current for medication management and restraint. The care manager and RN have the required interRAI training and competencies. All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. A performance appraisal schedule is in place and current staff appraisals were sighted in the staff files 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 | There is a documented rationale in place for determining service provider levels and skill mix. There is a register nurse on duty seven days per week. On call support after hours is provided by the facility managers (for non-clinical support), the care manager and the registered nurse. The minimum number of care staff on duty is during the night and consists of two caregivers. The roster was sampled and confirms that shifts are covered in the event of staff absence. There is a staff member with a current first aid certificate on each duty. Residents and family reported staff are available when they need them.  |
| 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 | A medicine management system is implemented that complies with current legislative requirements and safe practice guidelines. Allergies and indications are documented as well as necessary identifiers. Medication records are reviewed every three months. Weekly and six monthly controlled drugs stocktakes are conducted. The controlled drugs register was correct and current. A system is in place in returning expired or unwanted medications to the pharmacy. All medications are securely stored.Administration of medication was observed and confirmed safety and competency. Medication competencies are maintained. Administration records are maintained and were accurate.There is one resident who self-administers their medication. A system is in place to ensure safe storage and compliance in relation to self-administration of medications. Self-medication evaluations are completed monthly. The previous area for improvement regarding self-administration has been fully addressed. |
| 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 are prepared and cooked onsite. Cooked meals are transported from the kitchen to the main dining area via the lift. Meals are plated from the bain marie in the dining area while meals for the residents in the rooms are served on trays. The menu is reviewed by a dietician every two years.Food services policies and procedures include principles of food safety, ordering, storage, cooking, reheating and food handling. A system is in place when receiving and utilising kitchen supplies. Staff working in the kitchen have current food handling certificates. A kitchen cleaning schedule is implemented. Fridge and food temperatures are recorded daily.Residents are provided with meals that meet their food, fluids and nutritional. Dietary requirement forms are completed on admission and a copy is provided to the kitchen. Modified foods are provided as required. The meals are well-presented and the residents reported that they are provided with an alternative meal on request. Residents are weighed routinely. Those with weight decreases are provided with food supplements or fortified meals where appropriate. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Resident lifestyle plans are developed by either the care manager or registered nurse who are both interRAI assessors. Interventions are sufficiently detailed to address the desired goals/outcomes. Documented interventions are practical and staff reported that care plans are easy to follow. Monitoring forms are in use as applicable, such as weight, vital signs, wounds and behaviour. Wound assessment, monitoring and wound management plans are in place as required. The care manager has access to specialist services as required. |
| 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 | Activities provided are appropriate to the needs, age and culture of the residents. Activities are developed by the activities coordinator. Activities are developed using the residents’ profiles gathered during interview with the residents and their families. Weekly activities are posted in the common areas. Activity plans reflect the residents’ preferred activities and previous interests. A participation log is maintained and residents are referred to the care manager if changes in participation are noted. Interviewed residents and family members reported that activities are physically and mentally stimulating. The activities plan for the younger person with a disability includes physical, mental and social aspects relevant to their needs. A carer was organised by the family for regular outings. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident lifestyle plans, as well as, short term care plans are evaluated in a comprehensive and timely manner. Evaluations consider the residents’ degree of achievement towards meeting the desired goals/outcomes. The resident’s response to their treatment regime within the short term care plans is documented. Changes in the interventions in both long and short term care plans are made when goals are not achieved. Resolutions are documented in the short term care plans. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There have been no changes to the facility since the last audit. Trial evacuations are conducted as required. |
| 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 | Data on infections is collated monthly and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality assurance meetings and staff meetings. The necessary corrective actions are discussed. Incidents of infections are graphed and on display in the staff room. A comparison of previous infection rates is used to analyse the effectiveness of the programme.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service demonstrated that the use of restraint is utilised as a last resort in providing safety and comfort to the residents. There were no residents using a restraint or enabler at the time of the audit. Restraint minimisation and safe practice policies and procedures are in place, including clear definitions of restraints and enablers. Interviewed staff demonstrated good knowledge regarding restraints and enablers. All staff receive training on the use of de-escalation techniques. |

# 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.

|  |
| --- |
| 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 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | There have been a number of continuous quality improvement projects implemented. These have been implemented using the continuous quality improvement cycle. One project was implemented to reduce the number of falls. Data on falls was captured by ‘type’ and measured using a national benchmark. The programme commenced in April 2015 and was implemented over 18 months. Key staff attended national workshops and shared their knowledge, more internal education programmes were conducted, a working group and exercise class was commenced, additional equipment was purchased (landing mats and high low beds) and signage was improved. Quantitative data on falls over this period was fully analysed and measured in bed days. An evaluation was conducted. The total number of falls, and falls with harm, has reduced.A health and safety practices quality improvement project was implemented in response to changes in legislation. This project was implemented over a four month period and has resulted in improved use of the adverse event process and improvement in staff education and understanding. An evaluation of the project was documented.Catheter procedures were improved with an initiative which commenced June 2016 and was evaluated in December 2016. Improvements were made to staff education and recording requirements. Over a three month period the use of the new process was monitored. Recent data confirms that residents are staying dryer and not having to be changed so frequently. Feedback from family/support people is that these residents have had a better quality of life due to an effective catheterisation process. The induction process for staff who have English as a second language has been improved. The new initiative commenced in August 2016 and was evaluated in December 2016. Qualitative data suggests that the new process has improved competency and confidence of new staff.  | Quality initiatives have resulted in continuous improvements and improved outcomes for residents. |
| Criterion 1.2.3.7A process to measure achievement against the quality and risk management plan is implemented. | CI | Completed audits for 2016 – 2017 were sampled. Clinical indicators and quality improvement data was recorded on various registers and forms. Quality improvement data provided evidence that data is being collected, collated, and comprehensively analysed to identify trends and corrective actions developed and evaluated. | The internal audit process is implemented in a manner that demonstrates continuous improvement. |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | CI | Refer 1.2.3.6 and 1.2.3.7.  | The corrective action process is linked to the quality and risk management system and demonstrates continuous improvement and improved outcomes for residents. |

End of the report.