# Waverley Aged Care Limited - Waverley House Rest Home

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Waverley Aged Care Limited

**Premises audited:** Waverley House Rest Home

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

**Dates of audit:** Start date: 13 July 2015 End date: 13 July 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 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 privately operated by the current managers. The service is certified to provide rest home level of care for up to 20 residents in the rest home. On the day of the audit there were 20 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff. The non-clinical manager has considerable experience in aged care management and is supported by a part-time registered nurse.

Residents, family/whanau and general practitioner interviewed commented positively on the standard of care and services provided at Waverley House rest home. This certification audit identified an improvement required around meeting minutes and documentation of hazards, care plan documentation, interventions, aspects of medicine management and chemical safety.

## 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. |  |

Waverley House provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families/whanau. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified on-going involvement with community

## Organisational management

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

Waverley House has an established quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infections, internal audits, concerns and complaints and surveys. There is a business plan that aligns with the service mission statement and philosophy of care.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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

Residents and relatives receive adequate information on the services provided at Waverley House. The registered nurse is responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed within the required timeframes. The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.
Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete education and medication competencies. Improvements are required around medication management.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the residents. Resident’s individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. All kitchen staff are trained in food safety and hygiene.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The building has a current building warrant of fitness and fire service evacuation approval. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are utilised for group and individual activity. There is safe access to outdoor areas.

Resident’s rooms are single, personalised, and warm, with natural light and have call bells. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned maintenance schedule. Cleaning and laundry is done on site and there are documented policies and procedures for these services. Water temperatures are monitored. There are policies and procedures in place for emergency preparedness and civil defence equipment.

## 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. |

The service has policies and procedures to appropriately guide staff around the use of enablers or restraints. The registered nurse is the restraint coordinator. There are no residents using restraints and one resident using an enabler. The required documentation is in place for enabler use including voluntary consent. Staff receive training in restraint and managing challenging behaviour as part of the education plan.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is the registered nurse. There is a suite of infection control policies and guidelines that meet infection control standards. The infection control programme is reviewed annually. Staff receive annual infection control education. Surveillance is used to determine quality assurance activities and education needs for the facility.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained**Standards applicable to this service 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 | 40 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 85 | 0 | 6 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Waverley House rest home has current policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Three caregivers and one registered nurse (RN) were able to describe how they incorporate resident choice into their activities of daily living.  |
| 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 | Informed consent and advanced directives were evidenced in six of six resident files reviewed. All forms had been signed appropriately. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they are able to decline or withdraw their consent.There were six admission agreements sighted.Discussion with four families identify the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main foyer. Discussions with residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions.The resident files include information on residents’ family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | D3.1h: Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events (craft days, Art Deco week, and Returned Service Association events), church services and interest groups in the community. D3.1.e: Interview with residents confirm the staff help them access community activities.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The manager is the privacy officer and leads the investigation of any concerns/complaints in consultation with the RN for any clinical concerns/complaints. There have been no concerns/complaints registered since the previous certification audit. Management operate an “open door” policy. Residents and relatives confirmed they are aware of the complaints process. D13.3h: A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | There is adequate information available to residents/family about the services provided a Waverley House. This includes information about the Code and this is discussed during the admission process with the resident and family. Six residents and four family members interviewed confirmed they received all the relevant information during admission. D6.2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, and advocacy and Health & Disability (H&D) Commission brochure. D16.1bii: The relative and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are policies in place to guide practice in respect of independence, privacy and respect. Staff were observed during the audit, to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms. Residents interviewed confirmed staff respect their privacy, and support residents in making choice where able. Resident files are stored in a locked office.  The service philosophy is focused around promoting quality of life, involving residents in decisions about their care, respecting their rights and maintaining privacy and individuality within a family orientated environment. Resident preferences are identified during the admission and care planning process with resident/family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and integrated with the residents' care plan. Interviews with residents confirm their values and beliefs are considered. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | Waverley House has a Māori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There were no Māori residents on the day of audit. There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff interviewed were able to describe how they would ensure Māori values and beliefs are met. Staff attend cultural safety and awareness training two yearly. The service has access to a Māori advisor within the local district health board (DHB) Māori Health Unit.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Five care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. Six monthly reviews occur to assess if the residents needs are being met. Discussion with family and residents confirm values and beliefs are considered. Residents are supported to attend church services and religious activities of their choice in the community and on-site.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the five staff files sampled. Staff comply with confidentiality and the code of conduct. The RN and allied health professionals practice within their scope of practice. Staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the manager, RN and care staff confirmed an awareness of professional boundaries.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Waverley House policies and procedures meet the health and disability safety sector standards. New/reviewed policies are discussed at the staff meetings. Care staff stated they are kept informed of any changes to practice. Staff have access to internal and external training to ensure staff maintain skills and knowledge in aged care. There is allied health input into resident care as required. An environment of open discussion is promoted. Staff report the manager and RN are approachable, supportive and available after hours. Services are provided at Waverley House that adhere to the health & disability services standards. Staff complete relevant workplace competencies. Discussions with residents and family were positive about the care they receive.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Eleven of eleven incident forms reviewed for June 2015 identified family were notified following a resident incident/accident. The manager and RN confirm family are kept informed. The relatives interviewed confirmed they are notified promptly of any incidents/accidents. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). There is on-going discussion with families including the opportunity to participate in surveys. Regular newsletters keep residents and relatives informed on facility matters, activities and other services. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.There is access to an interpreter service through the local DHB.  |
| 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 provides care for up to 20 rest home level residents. On the day of audit there were 20 residents. The manager leases the building and the business is operated by the wife (manager) and husband (maintenance) team. The manager is non-clinical and has had twenty years aged care experience. She has been the manager/leasee of Waverley for the past 11 years. The manager is supported by an RN on-site from 9am to 2pm daily and on-call. The RN was previously employed as a long serving caregiver prior to commencing nursing studies. She graduated with a Bachelor of Nursing December 2014. ARC, D17.3di: (rest home). 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. Waverley House has reviewed the 2014 business plan. A SWOT (strengths, weakness, opportunities and threats) analysis of the business has been undertaken and a 2015- 2017 business plan developed which aligns with purpose, mission and values of the business. The licensee is responsible for all internal maintenance and 2014 improvements have included on-going refurbishment such as new lounge suite, new TV in lounge, TV aerials in all bedrooms, re-paint and signage of mobility van and upgrade of all gardens. Goals and ambitions for 2015-2017 are to complete the implementation of newly purchased policies, continue to implement the on-line training for caregivers and on-going refurbishment of bedrooms and office space. |
| 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 | The manager and RN are on-site daily. The manager is available on-call for facilities matters, privacy concerns and staff and resident/family support. The RN provides on-call support for clinical concerns. The facility has a close liaison with a similar size home close by and manager and RN resources are shared to cover periods of absence as required. D19.1a: A review of the documentation, policies and procedures and from discussion with staff, identified that the service has operational management strategies, quality assurance programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |
| 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. | PA Low | Waverley House is embedding a quality and risk management system. The service is in the process of reviewing the quality/risk management policies and procedures. The newly purchased policies (June 2015) meet accepted good practice and adhere to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A quality meeting follows the monthly staff meeting and is open to all staff. The quality committee comprises of health and safety and infection control personnel. Meeting minutes are made available to all staff. A review of meeting minutes identified outcomes of quality data is not recorded. An internal audit programme is being implemented and audits completed to date. The programme covers all aspects of the service including clinical audits. Improvements identified are acted upon. The annual resident care and food survey was conducted February 2015. Results have been collated and fed back to participants, as evidenced in resident meeting minutes (link 1.2.3.6). Relatives commented positively on the services provided at Waverley House. The resident care result was 98.6% and food service result 98.7%. D19.3: There is a Health and Safety and risk management system in place with policies currently under review. There is a hazard register in place for each service that requires updating. D19.2g: Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.  |
| 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 | Eleven accident/incident forms for the month of June 2015 were sampled. There has been RN notification and clinical assessment completed within a timely manner. Clinical assessments include neurological observations for un-witnessed head injuries and GP or hospital referral for assessment. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family/whanau had been notified promptly of accidents/incidents. D19.3c: The service collects incident and accident data and reports aggregated figures to the quality improvement and staff meetings. Staff interviewed confirm incident and accident data are discussed (link 1.2.3.6). D19.3b: The service documents and analyses incidents/accidents, unplanned or untoward events so that improvements are made. Trending data is collated and analysed. Discussions with the manager and RN confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.  |
| 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 human resources policies to support recruitment practices. Five staff files sampled contained all relevant employment documentation. Current practising certificates were sighted for the RN, diversional therapist (DT) and allied health professionals. Performance appraisals are up to date. The RN is not yet due for an annual appraisal. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. The education planner includes education requirements as well as additional clinical in service and external education. The RN completed InterRAI training June 2015. The RN interviewed, confirmed support and mentoring is available from other RNs within aged care, local InterRAI assessor and relevant DHB nurse specialists. The service is implementing on-line education for caregivers (link 1.4.1.1). Clinical staff complete competencies relevant to their role including medication.  |
| 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. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is an RN on duty Monday to Friday and on-call. A qualified DT is employed for 18 hours per week. A home assistant is employed seven days per week for laundry and cleaning.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident’s individual record. Resident records containing personal information is kept confidential. Individual resident files demonstrate service integration. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name. |
| 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 |  There are pre-entry and admission procedures in place. Written information on the service philosophy is included in an information pack for all new residents. Additional information on the service philosophy, advocacy and the complaints policy are included in the information pack.Four families interviewed stated they received sufficient information on the services provided. D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract. D14.1: Exclusions from the service are included in the admission agreement.D14.2: Information provided at entry includes examples of how services can be accessed that are not included in the agreement.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The service has discharge procedures in place to guide staff and these are followed in the event of a planned discharge. Relatives are notified of any transfers and contact is maintained. Transfer documentation maintained on the resident file. Information is provided to the receiving provider.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | There are policies and procedures in place for safe medicine management that meet legislative requirements. All care staff who administer medications have their competency assessed on an annual basis. A shortfall was identified around the RN medication competency. Education around safe medication administration has been provided. Staff observed administering medications, did not follow policy for administration. Standing orders are not used. On the day of audit there were no residents self-medicating. Shortfalls were identified around safe storage and the medication fridge.Ten of 10 medication charts had photo identification and an allergy status noted on the chart. Not all medication charts sampled, met legislative prescribing requirements.  |
| 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 Waverly are prepared and cooked on site. There is a four weekly seasonal menu, which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks in the dining rooms. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier. All food services staff have completed training in food safety and hygiene.  |
| 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 service has a process for declining entry should this occur, which includes informing the referring agency of the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau and relevant referral agency.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN completes an initial assessment on admission using risk assessment tools. Files reviewed identified that resident needs and supports have been identified through the on-going assessment process. The RN has completed 10 out of 20 resident InterRAI assessments as their review falls due. The diversional therapist (DT) completes an activity assessment that identifies individual activities and preferences. Cultural assessments were completed on admission and cultural and spiritual needs were reflected in the residents long term care plans.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident care plans reviewed were overall resident focused and demonstrated service integration. The care plans includes the residents needs/goals, however not all interventions were documented to meet the residents needs and supports. Residents and relatives confirm they are involved in the assessment process, however this was not documented. Short-term care plans are available for short term needs. In the residents files sampled not all change in health status were supported by use of short term care plans. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident's condition alters, the registered nurse initiates a review and if required, GP consultation. Relatives confirm they are notified with any changes to the resident health status including infections, accident/incidents and GP visits. A shortfall was identified around monitoring of weight loss for two residents.A wound assessment, treatment and evaluation was in place for one current wound (one skin tear). Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and this could be described by the RN. Residents and families reported satisfaction with the care delivered and confirm their needs are being met.  |
| 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 | A qualified diversional therapist is employed for 18 hours per week to plan and deliver the activity programme. Residents are assessed on admission as to their social history and their preferred activities (e.g. hobbies). The activity plan reflects the resident’s individual recreational and social needs. The activity programme, evidenced on the day of audit and discussed with the diversional therapist, covers a variety of activities such as: supervised walking in small groups for those consumers who enjoy walking, quizzes, bingo, outings (the facility has a 6-seater van which can accommodate 2 wheelchairs), exercises, crafts, entertainment, music, other board games and games suitable for indoors and newspaper reading. There is evidence of contact with external community groups such as local schools, SPCA, RSA and churches. Activities are planned monthly (confirmed in discussions with the diversional therapist). 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. D16.5d: Individual activity plans are reviewed when care plans are reviewed. Relatives and residents interviewed confirmed satisfaction with the activities offered.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the files sampled all initial care plans were evaluated by the RN within three weeks of admission. Long term care plans were reviewed at least six monthly or earlier with a change in health condition. Evaluations reviewed were resident-focused and described current progress. There was evidence in the files sampled of GP reviews at least three monthly or earlier if required. Short term care plans sighted has been evaluated regularly (link 1.3.5.2). On-going nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs. In managing the referral process, the service provides: a) appropriate transfer of relevant information and b) follow-up occurs where appropriate. The service uses the yellow envelope system when transferring residents to Hawke's Bay DHB. D16.4c: The service provided an example of where a resident’s condition had changed and the resident was reassessed for a higher level of care. D 20.1: Discussions with registered nurse identified that the service has access to the needs assessment and service co-ordination service, primary care and district nursing, specialist nurse advisors from the DHB, specialist medical services (including the older person’s mental health and allied health service, Hawke's Bay DHB) and laboratory services as well as other service providers as needed. |
| 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. | PA Low | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets are readily accessible for staff. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Blood and chemical spills kit are available. Shortfalls were identified around chemical safety including no chemical safety training since 2011.  |
| 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 has a current building warrant of fitness that expires 16 November 2015. There is a reactive and planned maintenance programme in place. Maintenance records are maintained. All electrical equipment has been tested and tagged June 15. Kitchen appliances are checked six monthly. The hoist has been calibrated. Hot water temperatures are monitored monthly. Contractors are available 24/7 for essential services. There is enough room throughout the service for residents to mobilise safely. Floor surfaces are clean and in good repair. Staff advised that they have enough equipment to provide the level of care documented in the care plan. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of toilets and showers with access to hand basins and paper towels. Consumer privacy is able to be respected. Hot water temperatures are monitored and maintained at 45 degrees. Communal toilets and showers are well signed and identifiable. The showers are spacious and allow for the use of shower chairs. Each toilet has hand washing facilities.  |
| 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 rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalize their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a single lounge and dining area. The majority of residents have their meals in the dining room although some residents choose to have their meals in the lounge area. Residents are able to access areas for privacy if required. All residents have their own rooms. Furniture is appropriate to the setting and arranged that enables residents to mobilise. D15.3d: There is a television, newspapers and access to a telephone for private calls available. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and housekeeping staff. Cleaning trolleys are kept in designated locked cupboards. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has an approved evacuation plan. Six monthly fire drills are held. Staff receive training in emergency management. There is at least one first aider on duty at all times. There is an emergency plan and disaster preparedness policies and procedures including a memorandum for alternative accommodation with a neighbouring facility. There is adequate water store, food supply, alternative cooking source and civil defence equipment available in the event of an emergency. There is an appropriate call bell system available. The facility is secure after hours with call bell access. The facility has ready access during the day and a keypad access to exit the main entrance. The keypad is visibly displayed and visitors were seen to exit the facility freely. The keypad links to the fire alarm. All residents and family sign consent for a safe facility with keypad exit.  |
| 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 | General living areas and resident rooms are appropriately heated with electric heating and ventilated by windows. Residents have access to natural light in their rooms and there is adequate external light in communal areas. All personal living areas have external windows.   |
| Standard 3.1: Infection control managementThere 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 | The infection control coordinator is the registered nurse who has been in the role since December 2014. Infection control committee meetings are held monthly. Infection control matters and infection rates are discussed with the manager and staff. The infection control programme has been reviewed June 2015. Visitors are asked not to visit if they have been unwell. There are hand sanitizers throughout the facility and adequate supplies of personal protective equipment. Residents and staff are offered influenza vaccines. There have been no outbreaks.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control is managed by the infection control coordinator who was appointed in July 2014. The infection control coordinator has attended on-site infection control education. The infection control coordinator has access to an external infection control consultant, district health board infection control personnel, laboratory services and GP service. There is adequate personal protective equipment readily available for staff.  |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been purchased from an infection control specialist June 2015 and reflect relevant legislation and accepted good practice.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education is provided annually and includes wound care, hand hygiene and food safety. Orientation includes infection control education and reading of policies and procedures. Resident education is expected to occur as part of providing daily cares and discussed at resident meetings as appropriate.  |
| 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 | Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator collects the infection rates each month. The data is analysed to identify trends and determine infection control quality initiatives and education within the facility. Infection control data is discussed with staff at the quality/health and safety/infection control meetings (link 1.2.3.6). Care staff interviewed, were aware of infection rates and infection control practice.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. There was one enabler in use and no restraints. There is a voluntary consent, pre-assessment, monitoring and three monthly review evidenced for the resident with an enabler. The use of enabler (cot side) and associated risks are identified in the long term care plan. The service demonstrated there has been a successful trial of removal of restraint. The registered nurse is the restraint coordinator. There is an approval group that meets three monthly to review the enabler use. Training in restraint and challenging behaviour has been provided. Waverley House continues to be operated as a locked facility and there is a digital lock on the front door. The policy is discussed with the EPOA or resident on admission and a consent is obtained. On the day of the audit, visitors, residents and family members are able to use the access code and leave and enter the building as they wished. |

# 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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| **Citerion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality data is collected for accidents/incidents, infections, internal audit outcomes and survey results. Quality data is discussed with staff who attend the meetings. | Discussion around quality data and matters arising from previous meetings is not reflected in the meeting minutes for staff reading. | Ensure outcomes, trends and improvements from quality data collected is recorded in meeting minutes. 90 days |
| Criterion 1.2.3.9Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;(b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Low | Each service area has a hazard identification register and control plan. Staff complete hazard identification forms and hazard control plans are identified. Hazards and corrective actions are discussed (and minuted) at the health and safety meetings.  | Hazard identification forms have not been completed and signed off as controls have been implemented. The hazard register does not include hazards and controls identified over the past year. | Ensure hazard forms are completed as required. Ensure the hazard register identifies all hazards.90 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | All medication administered had been signed as given on the medication signing sheets. As required medications administered were dated and timed on the signing sheet. Regular and as required medications are checked on delivery to the facility and are stored safely.  | This audit identified the following shortfalls around medicine management:1) The controlled drugs key was not kept on the person responsible for medications and the storage container was not fixed. 2) The medication fridge temperatures were not monitored. The medication fridge contained food and samples. 3) Caregivers observed administering medicines did not check the medication chart prior to administering medications. 4) Three of ten medication charts sampled, had not been reviewed by the GP 3 monthly. 5) Three of 10 charts sampled did not have documented indications “for as required”.  | Ensure medication management and documentation meet the required legislative standards for medicine safety as per the MOH medicines guidelines. 30 days |
| Criterion 1.3.12.3Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | Care staff receive annual education and complete medication competencies. | The RN has not completed the annual medication competency | Ensure the RN completes an annual medication competency.30 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 | Care plans developed include the resident’s active daily activities, including hygiene and grooming needs, mobilising, continence status, dietary requirements and other daily care needs. The service utilises a short term care plan for short term needs, however these have not always been developed when required. Short term care plans sighted in resident files for wounds and prevention of pressure injury.  | (1) Two of five files did not have interventions documented to manage acute changes in health status e.g. (i) one resident with a chest infection (link tracer) did not have a short term care plan in place and (ii) a second resident with a fractured neck of femur and a deep vein thrombosis did not have a short term care plan in place.(2) Three of five long term care plans did not describe interventions for the following (i) early warning signs and symptoms for deteriorating mental health, (ii) diabetic management for resident on insulin, and (iii) resident with hearing impairment.  | 1) Ensure short term care plans are developed for short term changes in health status. (2) Ensure long term care plans reflect interventions to meet the resident’s goals and needs. 60 days |
| Criterion 1.3.5.3Service delivery plans demonstrate service integration. | PA Low | Care plans record allied health input into care including GP visits, mental health services and nurse specialist input as required to meet the resident’s needs. The resident and families interviewed stated they are involved in the care planning process, however this was not documented. | There was no documented evidence of resident/relative involvement in the care planning process in five resident files sampled.  | Ensure there is documented evidence of resident/relative involvement in the care planning process. 180 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Interviews with staff identified that overall the services provided meet the residents assessments needs. However, interventions are not always fully documented to support needs (link 1.3.5.2). Nutritional assessments are completed on admission identifying the resident nutritional status. Residents are weighed three monthly.  | There was no weight monitoring in place for one resident with weight loss as per GP notes and one resident at risk of weight loss. | Ensure weight monitoring is in place for residents at risk of weight loss or identified weight loss. 60 days |
| Criterion 1.4.1.1Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | Chemicals were stored safely in the kitchen area. The cleaner’s trolley was well equipped with labelled chemical bottles. Chemical training was last completed 2011.  | (i) An uncovered bucket of flannels soaking in a bleach solution was sighted on the floor of a resident bathroom. (ii) Two containers of chemicals did not have manufacturer labels. (iii) Staff have not completed chemical safety training in the last two years.  | (i) Ensure all soaking of laundry is undertaken within the laundry area; (ii) Ensure all chemicals bottles are labelled correctly; and (iii) Ensure staff attend chemical safety training at least two yearly. 30 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.

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End of the report.