# Ambridge Rose Villa Limited - Ambridge Rose Villa

## 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 Villa Limited

**Premises audited:** Ambridge Rose Villa

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

**Dates of audit:** Start date: 15 December 2015 End date: 16 December 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:** 28

# 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. Ambridge Rose Villa provides rest home level care for up to 31 residents. There have been no significant changes to the facility since the last audit; however improvements have been made to the facility with ongoing refurbishments.

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.

## 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. The organisation involves family members on issues of consent, for those who are assessed as not competent.

Management and staff take all complaints and concerns seriously. There is a transparent and well implemented complaints management process.

## 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 facility manager, who is supported by the senior management team. This includes the chief executive officer (CEO), chief operations officer (COO) and the quality manager (QM). 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. Quality related data is entered onto an electronic data base, providing full analysis on trends and themes. The required policies and procedures are documented, reviewed and controlled. Comprehensive management and staff meetings ensures all quality activities are monitored and communicated throughout the organisation.

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

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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. |

Registered nurses are responsible for care plan development with input from residents, staff and family. Assessments and care plans are developed and evaluated within the required time frames.

Planned activities are appropriate to the residents’ assessed needs and abilities. In interviews, residents expressed satisfaction with the activities programme in place.

Medications are managed and administered in line with the medication management policy. Medications are monitored and reviewed as required. Staff involved in medication administration are assessed as competent.

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

## 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. |

The building has a current building warrant of fitness. Ongoing refurbishments are ensuring that the physical environment meets the needs of the residents and health and safety requirements. Maintenance requirements are monitored. Electrical and medical equipment is maintained and in safe working order.

All residents have private bedrooms. There are sufficient communal areas within the facility, and the gardens, for residents to enjoy. Outdoor areas are maintained and utilised by residents.

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

There is an approved evacuation plan and fire drills are conducted as required. The facility has civil defence kits and emergency management plans in place.

## 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. |

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. At the time of the audit there were no residents requiring restraint or enablers. Staff interviewed demonstrated a good understanding of restraint and enabler use.

The rest home is on a very busy road. There is a security gate at the entrance to the property. This is for security reasons and residents and visitors can come and go as they please. The required procedures are in place for the use of an environmental restraint.

## 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 prevention and control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training for staff.

Infection data is collated monthly, analysed and reported during staff meetings. Infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## 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** | 0 | 101 | 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). The Code is included in the orientation of all new staff. Training related to various elements of the Code is provided in an ongoing manner. This training is provided by a national advocacy service representative or the local Kaumatua and includes the Code, open disclosure, complaints, informed consent, dignity and respect, advanced directives and abuse and neglect.  Staff, residents and relatives interviewed, and observation during the audit, indicated that staff understand resident rights and their responsibilities and that residents 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 | The informed consent policy is in accord with the Right seven (7) of the Code. Situations where general written consent is required are defined and include outings, photos, treatments, and sharing of information with other health professionals. The required consents were sighted in records reviewed. These have been signed by the resident. In the event the resident has been deemed not competent to give consent, consent forms are signed by their enduing power of attorney (EPOA).  Residents’ choices regarding end of life care are discussed during the admission process. Resuscitation choices are documented and easily accessible. |
| 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 | The organisation has an open visiting policy. Visitors were observed to be made welcome. Interviews with residents and family members and observations during the audit confirmed that residents may freely receive visitors and may entertain their visitors in either the lounge areas, gardens or the privacy of their own rooms.  There is evidence that links with community resources are supported and facilitated. Families are encouraged to take their family member out if physically able. Residents are taken on trips into the local community in the facility van. Arrangements for attendance at specialist appointments are facilitated by staff as required. |
| 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 on admission. The process and forms are available in the entrance foyer. 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 resident meetings. Written complaints area added to the complaints register. The register includes the date, nature of complaint, action taken and resolution. There have been no formal (written) complaints since the last certification audit and none reported to external agencies. |
| 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. The Code is available in Maori and English.  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 was also sighted in residents’ rooms. Signed residents’ agreements were sighted in records sampled. Service agreements meet 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 | Procedures ensure residents are provided with services that support their independence (where applicable) and maintain their privacy and dignity. A review of care plans confirmed that personal and privacy needs are considered.  Residents' visual and auditory privacy is respected. All residents, with the exception of one couple, have single rooms. Rooms contain personal belongings and family interviewed stated the belongings are respected.  Interviews and observations confirmed that Ambridge Rose Villa is committed to ensuring residents are not subjected to abuse or neglect. The different types of abuse and neglect are defined within policies and guidelines. Reporting requirements, management of investigations, and follow up activities are also defined. All staff receive training on abuse and neglect.  Values and beliefs are respected. The organisation engages in the services of a local kaumatua. Public festivals and holidays are observed and celebrated. Results of a recent resident survey confirmed 100% satisfaction regarding the provision of respectful services. |
| 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 cultural safety policy addresses barriers to access for Maori residents and whanau. Cultural needs are included in the care plans (if identified). There is access to cultural advice, resources and documented protocols to ensure recognition of Maori values and beliefs for residents who identify as Maori. 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 | Resident’s personal needs are identified on admission. 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 on abuse and neglect and sexuality and intimacy. These include expectations 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 | Procedures and guidelines are suitable for the level and complexity of aged care services and include relevant good practice sources and references based on good practice principles. Relevant health strategies are referenced in policies and are consistent with national standards. Policies are regularly updated. Sufficient training (external and internal) is provided. Staff are encouraged to attend relevant conferences and the organisation is a member of New Zealand Aged Care Association.  Clinical practice is monitored. The nursing process is used for all assessments, care planning and evaluations. Assessment and care planning tools reflect good practice and clinical policies and procedures are developed and reviewed by registered nurses. Two nurses have completed interRAI training.  Satisfaction with nursing care and involvement with medical and health decisions is included in the satisfaction survey. These confirmed general satisfaction with the level of nursing/clinical care required. This was also supported by the general practitioner. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Interviews with staff, residents and families confirmed that communication is conducted in an open manner. Resident meetings occur and management has an open-door policy. Resident and family surveys are conducted and there is evidence that any issues raised are followed up and remedied.  Residents and family members interviewed stated they have the opportunity to talk to management or staff and are able to request changes if needed. Family members also stated that they are contacted if there is a change in a resident's health status.  All residents speak English as their first language, however it is reported that additional interpreter services can be accessed if required. There is one resident who is unable to communicate verbally. Details and related interventions for this resident are well documented in the assessment/care plan.  Satisfaction with communication is included in the satisfaction surveys and residents newsletters are completed monthly. Resident meetings are conducted six monthly. Informal events also provide opportunities for management, staff, residents and family to spend time together, for example barbeques. |
| 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. 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.  Organisational performance is monitored in an ongoing manner. The organisation chart defines the reporting lines throughout the organisation. The chief operating officer and the quality manager report directly to the chief executive officer and directors. Management reports sampled confirmed organisation performance and monitoring of achievement towards the strategic goals.  Day to day management is the responsibility of the facility manager. The facility manager is a registered nurse and has completed management and leadership training. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The facility manager is supported on a daily basis by the senior management team. This includes the CEO, COO, the QM and directors. It is reported that another registered nurse from the other facility can be utilised for clinical oversight in the event of a temporary absence of the facility manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk management framework is defined. 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. Staff are alerted to changes through the electronic business management system.  A range of quality related activities are conducted. Service delivery is monitored through complaints, surveys, health and safety, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. The organisation is continuing with the full implementation of an electronic system which provides a wide variety of reports and enables close monitoring and analysis of specified/chosen data.  There is a well-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.  A risk management programme is in place. This includes health and safety processes, hazard management and a well monitored risk matrix. There is evidence that business, environmental, clinical and financial risks are monitored. |
| 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.  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 reviewed. Each incident report had a corresponding note in the progress notes to inform staff of the incident. There is evidence of follow up from the GP, in the event of injury, 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 the 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. 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 the majority of staff have a current first aid certificate.  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. 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. There is one registered nurse on duty six days per week, with one registered nurse on call on the seventh day. There are two health care assistants assigned for each shift, with additional short shifts during busy times. The facility manager reports that skill mix is considered when developing the roster. This includes ensuring there are sufficient numbers of staff with current first aid certificates and medication competencies.  Residents and families interviewed confirmed staffing was adequate and met their needs. |
| 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 copies of resident information is stored securely in the nurses’ station. Review of resident 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. The registered nurse interviewed stated that in the event of transfer to hospital the relevant data accompanies the resident.  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 has all the required components on the management of enquiries and entry. Ambridge Rose Villa’s welcome pack contains all information about entry to the service. Assessment and entry screening processes are documented and clearly communicated to residents, their family/whanau of choice where appropriate, local communities, and referral agencies.  Admission requirements are conducted within the specified time frames and residents’ files sighted had admission agreement signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Residents 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 | The standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved for 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 medicine management system is implemented to ensure that residents receive medicines in a safe and timely manner. Policies and procedures comply with legislation, guidelines and best practice.  All medications are reviewed as required and discontinued medications are signed and dated by the GP, allergies are documented and photos present. Prescriptions are legibly written. An enrolled nurse was observed administering medications correctly. Medications and associated documentation is stored safely and securely and medication reconciliation is conducted by the facility manager and enrolled nurse when a resident is transferred back to the service.  The service uses individualised medication packs which are checked in on delivery and recorded on medication log by the facility manager. There were no expired or unwanted medications. The controlled drug register was current and correct. Weekly stock takes are conducted and all medications stored appropriately. There are no residents who self-administered their medications but there are self-administration policies and procedures in place if required.  Medication charts are reviewed three monthly by the attending GP. An annual medication competency is completed for all staff administering medications and medication trainings conducted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on site. The service employs two chefs and three kitchen hand assistants and all have current food handling certificates. The menu was reviewed by a dietitian to confirm it was appropriate for the nutritional needs of the residents. Meals are prepared in the kitchen and served to residents in two main dining rooms. Diets are modified as required. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. Resident’s weight is monitored regularly.  Supplements are provided to residents with identified weight loss issues. Nutrition and safe food management policies define the requirements for all aspects of food safety. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates were on all containers and records of temperature monitoring were maintained. Resident and family interviewed indicated satisfaction with the food service. |
| 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 facility manager reported that a declined entry register is in place. When a resident is declined entry, family/whanau are informed of the reason for this and other options or alternatives services available. The resident is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.  The facility manager reported that a declined entry decision is reached if the resident was considered not suitable for service or subject to bed availability. Ambridge Rose Villa records the reason for declining service entry to residents should this occur and communicates this to resident/family/whanau and refers them back to referral agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial nursing assessment is completed within 24 hours of admission while care plan and interRAI assessments are completed within three weeks according to policy. Assessments and care plans are comprehensive and include input from GP, resident, their family/whanau and medical specialists as appropriate. Registered nurses utilise standardised risk assessment tools on admission. In interviews, residents expressed satisfaction with the support provided. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long term care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans, short term care plans or infection screening forms for acute needs. Goals are specific and measurable and interventions are comprehensive to address the desired goals/outcomes identified during the assessment process. Residents and relatives interviewed confirmed care delivery and support is consistent with their expectations. Allied health care professionals provide input in the development of care plans such as GP, dietitian, podiatrist and activities coordinator. Staff members are informed about changes in the care plans through handovers and staff meetings. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Interventions are documented as per the identified objectives/goals. Care plans are developed incorporating information from all assessments. Documented evidence in the progress notes confirmed that required interventions were being provided. The GP confirmed that prescribed interventions are implemented and any significant changes are reported in a timely manner and prescribed orders carried out satisfactorily.  Resident files sampled had activities of daily living well documented and completed daily. Monthly nursing observations were completed and up to date. |
| 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 | Activities are appropriate to the needs, age and culture of the residents. The activities coordinators develop a yearly activity planner and daily/weekly activities are posted in the two main lounges’ notice boards. Residents’ files have documented activity plans that reflect the residents’ preferred activities of choice. Over the course of this audit, residents were observed being actively involved with a variety of activities. Individualised activity plans are reviewed after six weeks post formulation to evaluate effectiveness and six monthly or when there is noted decline in participation. The activities coordinator reported that they have group activities and one on one sessions with some residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long term care plans are evaluated in a comprehensive and timely manner at least six monthly and updated as changes occur. Reviews are fully documented and include current resident’s’ status, any changes and achievements towards goals. GP, staff, residents and family members input is included in all aspects of care and reviews/evaluations. Infection screening forms are completed similar to the short term care plans with all monitoring systems in place. |
| 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 utilises 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 internal referrals are facilitated by the facility manager/registered nurse and/or enrolled nurses. Records of the processes involved are maintained. |
| 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, household rubbish and recyclables are in accord with infection control principles and comply with local body requirements. A hazardous substances register is maintained. General waste management audits are routinely conducted.  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 is undergoing refurbishment. This commenced when the facility was purchased in February 2015 and is planned to continue for the next 12 -18 months. Refurbishments are conducted in a staged manner with minimal impact on the residents. Floorings, fixtures and fittings are being replaced/updated. There is also a planned maintenance programme, which ensures ongoing compliance requirements are met.  There is a current building warrant of fitness. All equipment is maintained and calibrated, as required. This includes the van. Electrical testing and tagging is conducted. 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. External gardens surround the facility. All external areas are safe and were being well utilised by residents on the days of the audit.  Staff report that sufficient supplies and equipment are provided. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are sufficient individual toilets and bathrooms provided. Some bedrooms have ensuites. All bedrooms have a hand basin. Bathrooms are well lit, fitted with hand rails, non-slip flooring, and call bells. Finishing materials are waterproof. Hot water is monitored routinely, where a variation occurs, this is followed up. There is hand gel throughout the facility. Ongoing refurbishments are ensuring all bathroom facilities have clear identification. Residents interviewed expressed no concerns regarding toilet, shower and bathing 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 | There are sufficient bedrooms to accommodate all residents. There is one double room. This is occupied by a couple. Rooms vary in size and are of sufficient size to accommodate residents allowing for mobility aids, equipment and staff caring for the resident. There is adequate room in all bedrooms for personal possessions. Each bed space is provided with a nurse call bell.  Residents and relatives interviewed confirmed that their bedrooms were adequate for their needs and their personal space is respected. Resident surveys confirm residents’ satisfaction with the cleanliness of their private rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are separate well-furnished lounges and dining areas. Activities are predominately provided in the lounge area. Alternative additional small sitting areas are available in each area. Communal areas are sufficient to accommodate all the residents. There is a variety of seating to suit all needs. Residents and relatives interviewed confirmed that the lounges and dining areas meet their needs. Satisfaction surveys provide residents/family with the opportunity to provide feedback regarding the facility. |
| 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 room 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. New laundry equipment is replaced as needed.  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. A well-equipped cleaning trolley with secure storage for chemical containers and a secure cleaning cupboard is provided. Cleaning staff are trained in the use of equipment and chemicals. Material safety data sheets are available in work areas.  Management monitors cleanliness and laundry standards through observations, resident/family feedback and internal audits. Interviews with staff, residents and family indicate satisfaction with facility cleanliness and the state of linen and personal clothing. |
| 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 training records that fire and evacuation training has been provided twice in the last 12 months. 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 the majority of staff have a current first aid certificate. 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. The facility is situated on a very busy road and the entire grounds are secure with a fence and gate with key pad entry. The key pad code is displayed so does not prevent entry and/or exit for residents. |
| 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 Villa provides a managed environment that minimises the risk of infection to residents, staff and visitors by implementing of an appropriate infection prevention and control programme. The facility manager is the infection control coordinator (ICC) and has access to external specialist advice from GP and district health board infection control specialists when required.  The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview with the ICC indicated that all infections are monitored through a surveillance system using an infection log. The infection control programme is reviewed annually.  Infection control is incorporated in the monthly meetings. Staff are made aware of infections through daily handovers on each shift and progress notes. Documented job description for the ICC including role and responsibilities is in place. Hand sanitisers and gels are available for staff and visitors to use. There has been no outbreaks documented and infection control guidelines are adhered to. |
| 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 ICC is responsible for implementing the infection control programme. Infection control matters are discussed at the management and monthly staff meetings, daily handovers and as when necessary. The ICC indicated there are adequate human, physical, and information resources to implement the infection control programme. The ICC has access to all relevant resident information to undertake surveillance, audits and investigations. |
| 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 | Policies and procedures for Ambridge Rose Villa are in place and reflect current best practice. Staff were observed to be compliant with infection control practices. Monitoring the implementation of infection control practice is the responsibility of the ICC. Staff were able to describe the requirements of standard precautions and knew where the policies and procedures are kept. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The ICC is a registered nurse and the facility manager. Annual infection control education is provided. A record of attendance is maintained. The training education pack is comprehensive and meets required legislative and current regulations. External resources included local district health boards, laboratories and GP to ensure education is current and reflect best practice. Training is conducted by the ICC annually through infection control student assessment questionnaire or as when necessary. |
| 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 of the facility and level of care provided. Information on all residents’ monthly infections, monitoring is reviewed. Infection data is collated and analysed to identify any significant trends or possible causative factors. Staff interviewed reported they are made aware of infection rates during daily shift handovers and monthly staff meetings. The GP is also informed when a resident has an infection and appropriate antibiotics prescribed in the process. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Staff actively work to minimise the use of restraint. All staff receive education regarding restraint minimisation and staff interviewed were clear regarding the difference between restraint and enabler use. The service currently has no residents using restraint or enablers although environmental restraint is in place via key pad entry at the outside gate. Family and residents were fully informed regarding the use of the secure key pad for entry/exit to the facility. |
| 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 facility manager/registered nurse is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to policy and procedure. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability 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 service acknowledges that the locked gate at the entrance to the facility was potentially an environmental restraint, for those who were unable to use the key pad. The required procedures were in place and there was evidence that this had been discussed, assessed and consented with the residents and family members. Residents and family were observed entering and exiting the grounds freely during the audit. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint approval process is in place and includes the facility manager, GP, resident and family member. Restraint use, if applicable, was discussed in management and staff meetings. The only restraint documented on the restraint register is the secure gate. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Risk minimisation was documented in care plans of the resident and the need for a restraint/enabler evaluated regularly. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | A full review of restraint and enable use is included in the management meetings. |

# 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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End of the report.