

Albany Rest Home 2004 Limited - Albany House

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](#).

The specifics of this audit included:

Legal entity:	Albany Rest Home 2004 Limited
Premises audited:	Albany House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 June 2017 End date: 27 June 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	21

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

Indicator	Description	Definition
	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

Albany House is certified to provide rest home and hospital level care for up to 25 residents. On the day of audit there were 21 residents.

The nurse manager/owner is actively involved in the running of the facility. The nurse manager is supported by an enrolled nurse (administrator) and a team of registered nurses and care staff.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included: a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

Residents and family members interviewed praised the service for the support provided.

Improvements are required around corrective action plans, completion of assessments and care planning.

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.
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The staff at Albany House ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints 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.		Some standards applicable to this service partially attained and of low risk.
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Performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan and quality plan have goals documented. There are policies and procedures to provide appropriate support and care to residents with rest home and hospital level needs. This includes updates around interRAI requirements and a documented quality and risk management programme that includes analysis of data.

Ongoing training is provided and there is a training plan developed and implemented for 2017. A review of rosters, observation of staffing levels on the days of audit and interviews with staff, family and residents indicate sufficient staff that are appropriately skilled with flexibility of staffing around client's needs.

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 low risk.
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for care plan development with input from residents and family. A review of a sample of resident files identified that assessments, were completed on admission and all long-term files had interRAI assessments.

Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medication management policies and procedures are documented in line with legislation and current regulations.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There were two residents using enablers and no residents using restraint.

Infection prevention and control

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

Standards applicable to this service fully attained.

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer (the registered nurse). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends. Infection rates are low.

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	42	0	3	0	0	0
Criteria	0	90	0	3	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff (two caregivers, two registered nurses and the activity coordinator) confirmed their familiarity with the Code. Five rest home residents, one hospital resident and two family members (hospital) interviewed, confirmed the services being provided are in line with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Five resident files sampled demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Caregivers interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Contact numbers for advocacy services are included in: the policy, in the resident information folder and in advocacy pamphlets that are available around the facility. Discussions with residents identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at reception. The residents and family members interviewed were aware of the complaints process and to whom they should direct complaints. The service received eight complaints in 2016 and three in 2017 YTD. The service captures all resident suggestions for improvement via the complaints process. All complaints have: noted investigation, timelines, corrective actions when required and resolutions. Residents advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that includes the Code of Rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identify they are informed about the code of rights. The nurse manager (owner) provides an open-door policy for concerns or complaints. Resident meetings have been held providing the opportunity to raise concerns in a group setting. Advocacy pamphlets, which include contact details, are included in the information pack. The service has an advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. Residents' files include their cultural and/or spiritual values when identified by the resident and/or family. Residents and relatives interviewed confirm the service is respectful. Discussions with residents confirm that they are able to choose to engage in activities and access community resources. Staff receive education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. There were no residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of different cultural needs of residents and their whānau. The service has developed links with Matarua Districts Marae and has access to the SDHB Māori liaison service for assistance or advice when required. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff have had training around cultural safety.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from</p>	FA	<p>Evidence:</p> <p>The staff employment process includes the provision of a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues which are provided to staff on</p>

<p>any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>employment. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced on interview with the care staff. Interviews with staff confirm their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The quality assurance and risk management policy is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The 2016 resident and relative satisfaction survey reflects high levels of satisfaction with the care that is provided. The nurse manager is responsible for coordinating the internal audit programme. Policies and procedures have been reviewed. These are available in hard copy. Quality improvement/staff meetings and resident's meetings have been held. Residents and relatives interviewed spoke very positively about the care and support provided by caregivers and registered nurses. Staff had a sound understanding of the principles of aged care and state that they are well supported by the registered nurses, enrolled nurse and nurse manager.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies are in place relating to open disclosure. The reporting of incidents and accidents policy had been updated to reflect the requirement to notify relevant authorities in relation to essential notifications and includes those requiring a Section 31 notification to the Ministry of Health. Residents interviewed state they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member's health status. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services. There were no residents needing to use this service at the time of audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Albany House is an independently owned service that provides rest home and hospital level care for up to 25 residents. On the day of audit, there were 21 residents, 11 rest home and 10 hospital residents. Of the ten hospital residents, three were on respite care and one was on a long-term chronic health contract. The facility has twenty dual-purpose beds which can be used for the provision of rest home or hospital level care.</p> <p>The nurse/manager (owner) is on site Monday – Friday and can be contacted to support staff after hours. The nurse manager is supported by an enrolled nurse, who performs an administration role, care staff and registered nurses.</p> <p>The goals and direction of the service are documented in the business plan and the progress toward goals has</p>

		<p>been documented.</p> <p>The nurse manager has completed eight hours annually of professional development activities related to managing an aged care residential facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>During the temporary absence of the nurse manager the registered nurse with support of the enrolled nurse (administrator) performs this role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The nurse manager facilitates the quality programme and ensures the internal audit schedules are implemented. The nurse manager has reviewed and updated the resident file internal audit to include contractual requirements. Corrective action plans are developed, implemented and monitored via the quality improvement meeting minutes when service shortfalls are identified.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality improvement data is discussed at the quality improvement/staff meetings. The service uses the quality improvement meetings to develop and document corrective actions required, however there is no allocation of the person(s) responsible or timeframe for completion identified. Resident meetings have been held regularly.</p> <p>There are policies and procedures provided by an external aged care consultant that are relevant to the service types offered. The policies are reviewed and updated if there is a change in legislation, guidelines or industry best practise. The quality improvement/staff meeting minutes evidence discussion of revised policy documents. Clinical policies reflect the interRAI requirements.</p> <p>There is a current risk management plan. Hazards are identified, managed and documented on the hazard register. There is a designated health and safety officer. Health and safety issues are discussed at quality improvement/staff meetings with action plans documented to address issues raised.</p> <p>There are resident/relative surveys conducted and analysed. The February 2017 resident/relative survey has been distributed. The 2016 survey results evidence overall satisfaction with the service. Falls prevention</p>

		strategies are in place for individual residents.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Eleven incidents (all incidents from April – June to date) demonstrated appropriate documentation and clinical follow-up. Accidents and incidents are analysed monthly with results discussed at quality improvement/staff meetings.</p> <p>The management team are aware of situations that require statutory reporting. No events have required reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Five staff files sampled (a registered nurse, the cook, the activities coordinator and two caregivers) show appropriate employment practices are documented. Current annual practising certificates are kept on file.</p> <p>The orientation package provides information and skills around working with residents with rest home and dementia level care needs and were completed in all staff files sampled.</p> <p>There is an annual training plan in place and implemented. All staff files reviewed for staff who have been employed for more than 12 months contain a current annual performance appraisal.</p> <p>Residents stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for staffing the service. The nurse manager (owner) works Monday – Friday and provides on-call after hours support to the staff. The enrolled nurse (administrator) holds a current practising certificate, works full-time, and provides support to staff and the nurse manager.</p> <p>On the day of audit there were 21 residents, 10 hospital and 11 rest home level care residents.</p> <p>A review of four weeks rosters, observation of staffing levels, monitoring of call bell response times on the days of audit, interview with family, residents and staff confirmed that staffing levels are adequate and that management are visible and able to be contacted at any time. The roster evidenced increases in staffing to meet resident needs and occupancy levels and replacement of staff to cover staff sickness and annual leave.</p> <p>There is a registered nurse on duty on each shift.</p> <p>The registered nurse on the morning and afternoon shifts is supported by two caregivers. At night one</p>

		registered nurse and one caregiver are on duty.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so.</p> <p>Individual resident files demonstrate service integration.</p> <p>Entries are legible, dated and signed by the relevant staff member including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has admission policies and processes in place. Residents and family members receive an information pack outlining services able to be provided, the admission process and entry to the service. The service screens all potential residents prior to entry and records all admission enquiries. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the nurse manager or registered nurse. The admission agreement form in use aligns with the requirements of the Age Related Residential Care Services Agreement. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed. The service uses the DHB yellow envelope system to ensure that relevant information is communicated to the DHB. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. Respite residents are supported to transition back home when ready. Communication with families is well documented around exit. Transfer plans are completed and communicated to the relevant health professionals.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that</p>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. The medication charting reviewed met legislative requirement. Discontinued medications were dated and signed by the GP. All 'as required' medications had an indication for use. Medication is appropriated, stored and expired medication is disposed of as per policy. Medication reconciliation occurs on admission. All ten medication</p>

<p>complies with current legislative requirements and safe practice guidelines.</p>		<p>records reviewed evidenced that medication has been administered as prescribed. Registered nurses (including the nurse manager), the enrolled nurse and caregivers are responsible for the administration of medications. Staff who administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RN reconciles the delivery of the packs from the pharmacy and documents this. Medication charts are written by the GP and there was documented evidence of three-monthly reviews. Medications reviewed were prescribed and charted in line with guidelines. There were no residents self-administering. Medications requiring refrigeration are stored in a sealed plastic container in the kitchen fridge. The temperature of the fridge is monitored and remains within acceptable ranges.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. There are three day cooks and five tea cooks at the service, who prepare and cook all meals on-site. All cooks have a current food control plan certificate with the Gore District Council. The summer and winter menus have been reviewed by a dietitian.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. The registered nurses complete the dietary requirement forms on admission and provide information to the kitchen. Additional or modified foods are also provided by the service. The cook could describe each individual resident's requirements, likes and dislikes.</p> <p>Chiller, freezer and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen directly to the dining room. The residents confirmed that they are provided with alternative meals as per request. All residents are weighed regularly. Residents with weight loss are provided with food supplements.</p> <p>Residents and family members interviewed spoke positively about the meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents, should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred to the referring agency for appropriate placement and advice.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The registered nurses utilise standardised risk assessment tools on admission and the interRAI assessment tool. InterRAI assessments, assessment notes and summary were in place for all resident files reviewed, however not all were completed within the required timeframes (link 1.3.3.3).</p> <p>Pain assessments were evidenced completed for all residents on admission and these were reviewed six-monthly or completed when a new episode of pain was reported. Monitoring of the effectiveness of the administration of 'as required' medication was noted in progress notes. The frequency of administration of 'as required' medication for breakthrough pain was monitored by the registered nurses. The nurse manager and registered nurses interviewed reported that any residents reporting or experiencing an increase in pain was referred to the GP for a review of pain management plan.</p> <p>The long-term care plans reviewed reflected the outcome of the assessments and goals were identified.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans reviewed described areas of the support required to meet the resident's goals, needs, and identified allied health involvement under a range of template headings. Care plans evidenced evaluations. Residents and their family were documented as involved in the care planning and review process. Short-term care plans (STCP) are in use for changes in health status. Short-term care plans have been regularly reviewed and signed off when resolved. Care staff interviewed could explain the care and support needed for all residents in their care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management.</p> <p>Caregivers, the enrolled nurse and the registered nurses follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., physiotherapist and speech language therapist). If external medical advice is required, this will be actioned by the general practitioner (GP) or nurse manager. Staff have access to sufficient medical supplies (e.g., dressings). Continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Monitoring charts are available, including blood sugar monitoring forms with acceptable ranges documented, and registered nurses interviewed could describe when these have been used. Weights, observations, food and fluid charts and blood sugar monitoring were completed as per care plan interventions. Residents with weight loss were identified. The care plans were evaluated three to six-monthly or sooner to evidence achievement of the desired goals or outcomes. Changes in the resident needs identified through the evaluation process were not always updated in the care plan interventions. However, as interventions were evidenced to be implemented the risk has been assessed as low.</p>

		<p>Wound assessment, treatment and wound management plans are in place for one resident with a chronic vascular wound. The wound is reviewed regularly by the vascular wound service.</p> <p>Registered nurses interviewed could describe access to specialist services if required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>The service has one activities coordinator with 12 years' experience working two hours per afternoon Monday to Friday. The activities coordinator interviewed discussed a monthly plan of activities, which has been developed with residents. Activities include (but not limited to) newspaper reading, housie, happy hour, outings, church services, quizzes, bowls and games. Interviews with residents identified that activities provided were appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The service has a van with outings scheduled weekly.</p> <p>Each resident has an individual activities assessment on admission and from this information an individual activity care plan is developed. Implementation of the activities plan is evaluated monthly and attendance records are maintained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plan evaluations were sighted in resident files reviewed. These have been completed six-monthly or sooner when there is a change in condition or care requirements. Evaluations are documented assisted by the interRAI tool and document progress toward goals. There is at least a three-monthly review by the GP. Short-term care plans reviewed had been evaluated and closed out or added to the long-term care plan where the problem was ongoing.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Waste management procedures are addressed in the safe environment and health and safety manuals. The staff orientation process includes chemical usage, hazard management and the use of material safety datasheets. All hazardous chemicals are stored in secured areas. Sharps bins are available. The sluice and laundry contains protective equipment including gloves, eye protection and aprons. Hats are worn by food service staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Albany house is a single storey building. Fixtures and fittings are appropriate and meet the needs of the residents. There is a current building warrant of fitness which expires 26 June 2018. The outside areas are landscaped, with pathways and garden beds. Hot water temperatures are monitored by the maintenance person.</p> <p>Medical equipment including scales have been checked and calibrated in April 2017. Testing and tagging of electrical equipment has been conducted.</p> <p>Pressure-relieving mattresses and cushions, shower chairs and slide sheets are available and in use.</p> <p>Flooring surfaces are made of non-slip materials. The policy on transportation and vehicle usage describes transportation requirements. Building compliance activities are completed and signed out. There is a documented preventative and reactive maintenance programme. A maintenance person is employed to attend to all maintenance and repairs. Preventative and reactive maintenance issues are addressed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal</p>	FA	<p>Albany House has 25 resident rooms. Each room has a hand basin. There are adequate numbers of communal toilets and showers. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene.</p> <p>Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets and in all resident rooms. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs. Bathrooms are large enough to ensure that residents who require assistance are managed safely. There is a staff/visitor toilet.</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All rooms are spacious enough to allow residents to safely move about the furnishings with their mobility aids. Residents have personalised their rooms.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Albany House has a large dining room and two separate lounges. Seating and space is arranged to allow both individual and group activities to occur. Residents interviewed confirmed satisfaction with the communal areas.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service has policies and procedures for the management of laundry and cleaning practices. Product user charts, chemical safety datasheets for chemicals used in the facility, cleaning manuals and task sheets were reviewed. Housekeeping staff are employed to attend to cleaning and laundry. Residents and relatives interviewed confirmed the facility is kept clean and tidy and there were no concerns around the laundry service.</p> <p>The laundry has a dirty to clean flow in the laundry. All laundry is completed on site. Chemicals are stored in a locked cleaning cupboard. Additional storage of bulk chemicals is located adjacent to the laundry in a secure cupboard. Cleaning and laundry audits are included in the annual audit schedule.</p>
Standard 1.4.7: Essential, Emergency, And Security	FA	There are emergency management plans in place including pandemic, civil defence and other emergencies. Fire evacuation practice documentation was sighted. A contracted service provides checking of all facility

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>equipment including fire equipment. Fire training and emergency procedures are included in the staff education and training programme.</p> <p>There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is on duty on each shift.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity or where required, a sensor mat was in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and bedrooms are appropriately heated and ventilated. Heating is provided by large panel heaters and night store heaters. The facility was of a comfortable temperature on the day of audit. Room temperatures can be individually adjusted. Residents have access to natural light in their rooms and there is adequate external light in communal areas.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>Albany House has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control nurse with support from all staff. Infection control matters are routinely discussed at all quality improvement/staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and</p>	FA	<p>There are adequate resources to implement the infection control programme. The registered nurse (infection control nurse) is responsible for infection prevention and control. The infection control team is all staff through the quality improvement/staff meeting. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>

information resources to implement the infection control programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The staff orientation programme includes infection control education. The infection control person has completed infection control updates and provides staff in-service education which has occurred in 2016. Education is provided to residents in the course of daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at quality improvement/staff meetings and results are posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. The infection rate is very low and there have been no outbreaks.

programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service philosophy includes that restraint is only used as a last resort. There were no residents assessed as requiring the use of a restraint at the time of audit. Two rest home residents had requested the use of a bed rail to assist with maintaining their independence. The residents used a bed rail to assist with repositioning when in bed. The care plans reviewed documented the use of the enabler and the risks associated with their use. Progress notes evidence monitoring was occurring as per care plan instructions and policy. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. Staff have been trained in the management of behaviours that challenge and restraint and enabler use.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is a quality improvement/staff meeting to which all staff are invited. Aspects of the quality programme include (but not limited to): complaints, health and safety, accidents and incidents, internal audit outcomes, infections and risk management are discussed and documented in meeting minutes. Resident meetings are held. Small resident and staff numbers and open discussion, means issues are discussed with management as they arise. The service uses the quality improvement/staff meeting minutes to develop corrective actions when shortfalls are identified. However, specific detail as to the persons responsible and timeframe for completion of corrective actions were not consistently documented.	When shortfalls are identified by the service, quality improvement meetings do not consistently evidence who is responsible for the implementation/follow-up of corrective actions and the timeframe for completion.	Ensure quality improvement/staff meetings identify those responsible for the implementation of corrective actions and the timeframe for completion. 60 days
Criterion 1.3.3.3	PA Low	Permanent resident files reviewed evidenced that initial interRAI assessments, long-term care plans and GP visits were completed. Two	i) One rest home and one hospital file reviewed	i) Ensure that interRAI

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>of four permanent residents had interRAI assessments and long-term care plans completed within contractual time frames.</p>	<p>evidenced the interRAI assessment was not completed within 21 days of admission.</p> <p>ii) One hospital resident (recent admission) did not have the long-term care plan completed within 21 days of admission.</p>	<p>assessments are completed within the required timeframes, in accordance with contractual requirements.</p> <p>ii) Ensure all permanent residents have a long-term care plan developed within 21 days of admission.</p> <p>60 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Two of four long-term care plans evidenced that interventions were updated following a change in resident need identified during the evaluation process. Three of four permanent resident files reviewed evidenced that care plans were evaluated six-monthly. (The fourth file was a recent admission).</p>	<p>i) One long-term care plan for a hospital resident had not been updated to reflect interventions implemented for weight loss. ii) One long-term care plan for a rest home resident had not been updated to reflect interventions implemented to assist with resident mobility.</p>	<p>Ensure care plans are updated to reflect current interventions being implemented.</p> <p>60 days</p>

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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.