# Aversham House Rest Home 2017 Limited - Aversham House

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Aversham House Rest Home 2017 Limited

**Premises audited:** Aversham House

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

**Dates of audit:** Start date: 15 September 2017 End date: 15 September 2017

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 17

# 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.

## General overview of the audit

Aversham House provides rest home level care for up to 21 residents. On the day of the audit there were 17 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owner. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, staff and management.

The current owner/manager is a registered nurse and supported by a part-time registered nurse, enrolled nurse, senior caregivers and long serving staff. Residents interviewed were complimentary of the service and care they receive at Aversham House.

The prospective owner (registered nurse) reported the current policies, systems and staff will remain in place following the purchase. The current owner/manager will continue to provide support to the new owner for at least six months following purchase.

The provisional audit identified areas for improvement around meeting minutes and quality data, training, timeframes around interRAI assessments and care plan development, fire drills and civil defence supplies.

## Consumer rights

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents interviewed spoke positively about care provided at Aversham House. Complaints processes are implemented and complaints and concerns are managed. Annual staff training reinforces a sound understanding of resident’s rights and their ability to make choices.

## Organisational management

Aversham House has a documented quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazard management. There is a monthly staff meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times.

## Continuum of service delivery

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews each resident’s needs, outcomes and goals at least six-monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurse and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three-monthly.

An activity team implements the activity programme for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes are accommodated.

## Safe and appropriate environment

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised. There are a mix of rooms with ensuites and communal shower/toilet facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

The service maintains a restraint free environment. There are policies and procedures to follow in the event that restraint or enablers were required. On the day of the audit there were no residents using restraints or enablers. The registered nurse is the restraint coordinator. Restraint education is included in the two-yearly training programme.

## Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Responsibility for infection control is shared between the owner/manager and a senior caregiver. The infection control coordinators have attended external education and coordinate education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 41 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 2 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The service has available information on the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code). Advocacy pamphlets and the Code of Rights are clearly displayed at the main facility entrance. Five residents (interviewed) confirmed that information has been provided around the Code of Rights. No relatives visited on the day of audit. There is a resident rights policy in place. Discussion with three caregivers identified that they were aware of the Code of Rights and could describe the key principles (link 1.2.7.5). |
| 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 | There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. All five resident files contained signed consents.  Resuscitation status had been signed appropriately. Advance directives were signed for separately identifying the resident’s wishes for end of life care, including hospitalization. Copies of enduring power of attorney (EPOA) where available were in the residents’ files.  An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whanau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.  Residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.  Five long-term resident files reviewed had signed admission agreements. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code and advocacy pamphlets on entry. Resident advocates are identified on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents confirmed their understanding of the availability of advocacy services. Caregivers interviewed were aware of the resident’s right to advocacy services and how to access the information. |
| 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 service has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. Residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed visiting the home. Residents verified that they have been supported and encouraged to remain involved in the community. The service has a van and group outings are provided. Community groups visit the home as part of the activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the owner/manager using a complaints’ book (register). There have been no complaints made in 2016 or 2017 year-to-date. Residents interviewed advised that they are aware of the complaints procedure. Staff interviewed could describe the complaints process (link 1.2.7.5). |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome information folder that includes information about the Code of Rights. There is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. The owner/manager is available to discuss concerns or complaints with residents and families at any time. Residents interviewed stated they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.  The prospective new owner is currently employed as a registered nurse in clinical research and is knowledgeable in the Health & Disability Commissioner Code of Rights and applies the code of rights in practice in their current role. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed could describe how they maintain resident privacy. Staff sign a privacy declaration on employment. The owner/manager is the privacy officer and has an open-door policy. Residents interviewed confirmed they have freedom of choice and their values and beliefs are respected. Care plans reviewed identified values & beliefs are documented. Staff interviewed and documentation reviewed identified there were no incidences of abuse & neglect and staff could describe definitions of abuse & neglect and their responsibilities for reporting (link 1.2.7.5). |
| 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 | There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. The service has established a link with local iwi who provides advice for staff and advocacy for Māori. On the day of the audit there was one resident that identified as Māori. |
| 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 | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognises and responds to values, beliefs and cultural differences. Staff attended cultural awareness training in May 2016. Residents are supported to maintain their spiritual needs with regular on-site church services and attending other community groups as desired (link 1.2.7.5). |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of a service Code of Conduct. Professional boundaries are defined in job descriptions. Staff are observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with three caregivers and the RN could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The owner/manager is committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. All residents interviewed spoke positively about the care provided. The service has implemented policies and procedures from a recognised aged care consultant to provide a good level of assurance that it is adhering to relevant standards. Staff interviewed had a sound understanding of the principles of aged care and state that they feel supported by management. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Management promote an open-door policy. Residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Information is provided in formats suitable for the resident and their family. Residents and family are informed prior to entry of the scope of services and any items that are not covered by the agreement. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Twelve incident forms reviewed identify that family were notified following a resident incident. The information pack is available in large print and advised that this can be read to residents. Interpreters are available as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Aversham House provides care for up to 21 rest home residents. On the day of audit there were 17 residents. All long-term residents are under the Aged Residential Related Care (ARCC) agreement. The business plan and goals have been developed for 2017. The plan includes quality indicators, person responsible and timeframe for implementation. Goals include review of staff wages, maintaining high occupancy and improving attendance at staff meetings.  Aversham House is managed by a registered nurse (RN) who has owned and operated the home for the last eleven and a half years. The owner/manager/RN and husband are directors. The company is supported by an accountant for financial matters and accounts. There is an administration person on-site. The owner/manager is supported by a RN who has been in the role for three and a half years and is employed for 26-30 hours a week. The owner/manager and RN share the on-call duties.  The owner/manager has maintained at least eight hours annually of professional development related to managing a rest home.  The prospective new owner (interviewed by phone) has completed a nursing degree in Auckland in 2013 and achieved honours in 2015. He has been working as a RN in clinical research for the last three and a half years. Previous work experience includes an emergency medical dispatcher, healthcare assistant and nursing assistant. During his nursing studies, he undertook placements in geriatric and rehabilitation wards. The prospective new owner does not have any work experience in the aged care sector however the current owner will transition the prospective new owner into the aged care sector, understanding compliance and support him through the process for at least a six-month period. The RN and enrolled nurse along with the senior caregiver (second in charge) will remain employed under the prospective new owner who will take on a management role and provide clinical support as needed, on duty as required and share the on-call. A copy of his current annual practicing certificate was sighted.  The expected settlement date is 31 October 2017. The DHB is aware of the pending change of ownership. The transition plan confirms there will be no changes to management or clinical systems, policies or procedures during the first year of ownership. The prospective new owner will continue current memberships with established professional bodies. |
| 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 | During the temporary absence of the owner/manager, the senior caregiver/assistant manager is the acting manager with the support from the RN. The same arrangement will continue in the event of temporary absence of the prospective new owner. |
| 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. | PA Moderate | The service has a business, quality risk assessment and management plan and this includes a quality plan. The service has in place a range of policies and procedures to support service delivery that have been developed by an aged care consultant and are reviewed regularly.  The service has an annual meeting schedule in place however, quality/management meetings have not been held as scheduled. The staff have input into the monthly staff meetings. Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected, however, staff meeting minutes do not evidence discussions around quality data.   The owner/manager facilitates the quality programme and ensures the internal audit schedules are followed. Corrective action plans are developed and signed off when service shortfalls are identified. There are resident surveys conducted annually. The survey for May 2017 evidences that residents are overall satisfied with the service provided. The service has implemented a health and safety management system. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. There is a designated health and safety representative (senior caregiver). Falls prevention strategies are implemented for individual residents and the identification of interventions on a case-by-case basis to minimise future falls.  The prospective new owner confirmed on interview that there will be no changes to the current quality and risk management system or policies and procedures. The current owner/manager will be available to mentor the prospective new owner to the quality risk system. |
| 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 | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions. Twelve incident forms reviewed from July/August 2017 evidenced that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. All incident forms are signed off by the RN or owner/manager. The caregivers interviewed could discuss the incident reporting process. The owner/manager collects incident forms, investigates and reviews, and implements corrective actions as required. Discussions with the owner/manager confirmed that she is aware of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resources policies to support recruitment practices. The owner/manager, RN and GPs practising certificates were sited. Five staff files were reviewed (one RN, two caregivers, one activities person and one cook). The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes a documented checklist relevant to the area of work, health and safety induction and infection control questionnaires. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  There is a two-yearly education plan in place that includes all required education as part of these standards, however, not all compulsory education had been completed. Interviews with caregivers, RN and cook confirm in-service education is provided on-site and externally. The owner/manager and RN attend external training including conferences, seminars and education sessions with the local district health board (DHB). The manager and RN are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The owner/manager (RN) is on-site 40 hours per week from Monday to Friday. The owner/manager is on call after-hours for any operational and clinical issues with the assistance of the RN. The local general practitioner (GP) also provides after-hours care if required and caregivers have access to the local ambulance service. Interviews with caregivers and residents identify that staffing is adequate to meet the needs of residents.  There is an RN on-site on the morning shift (for 6.5 to 7.5 hours) for four days during the week from Tuesday to Friday. In the rest home (17 residents), there are two caregivers on the morning shift, one long shift (7am to 3pm) and one short shift (7am to 1.30pm), two caregivers on the afternoon shift, one long shift (3pm to 11pm) and one short shift (4pm to 9pm) and one on the night shift (11pm to 7am). There is an additional caregiver on duty in the morning (7.00 to 10.30pm) to assist with showering and the morning breakfast. Staff interviewed confirmed that management are visible and able to be contacted at any time.  The prospective owner stated there will be no changes to staff who will transfer to the new owner on the date of settlement. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and resident register. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation. |
| 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 | Residents’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Five long-term admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs, enrolled nurse and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided. Medications (blister packs) are checked on delivery against the medication chart on the electronic medication system. Any discrepancies are fed back to the pharmacy. All medications are stored safely. Standing orders are not used. There were no residents self-medicating.  Ten medication charts were reviewed on the electronic medication system. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three-monthly. The administration signing sheets reviewed identified medications had been administered as prescribed. |
| 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 and home baking is prepared and cooked on-site by qualified cooks. Staff have completed food safety training. There is a four-weekly seasonal menu which had been reviewed by a dietitian in September 2017. The cook receives dietary profiles for new residents and is informed of any changes to resident’s dietary needs. Dislikes are accommodated. Additional or modified foods are provided as required. Residents interviewed were very complimentary about the meals provided.  Fridge, freezer and end cooked temperatures are monitored and recorded daily. All perishable goods are date labelled. A cleaning schedule is maintained. |
| 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 | There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RNs complete an initial assessment on admission including risk assessment tools as appropriate. InterRAI assessments had been completed for all five resident files reviewed (link 1.3.3.3), or earlier due to health changes for residents under the ARCC. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the care plan. The long-term care plans in place (link 1.3.3.3) reflect the outcome of the assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Four of five residents’ long-term care plans reviewed (link 1.3.3.3.) were resident-focused and individualised. Care plans documented the required supports/needs to reflect the resident’s current health status. Relatives interviewed confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative involvement in the development of care plans.  Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan.  There was evidence of allied healthcare professionals involved in the care of the resident. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the RN initiates a review and if required, GP, NP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Family notifications were documented on the family contact page in the residents’ files reviewed.  Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan (includes dressing type and evaluations on change of dressings) were in place for two lesions. There were no pressure injuries on the day of audit. There is access to the DHB wound nurse specialist for advice for wound management as required.  Continence products are available. The residents’ files include a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain and challenging behaviours. |
| 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 | Two staff share the activity coordinator role to coordinate and implement a Monday to Friday activity programme from 10.00am to 4.30pm. Both activity coordinators have a current first aid certificate. They attend monthly regional meetings with other activity coordinators to maintain knowledge, skills and to share ideas.  Activities provided meet the resident recreational preferences. Activities are meaningful and include (but are not limited to); newspaper reading and discussions, quizzes, walks, exercises (Tai Chi), reminiscing, entertainment and outings. The service has an 11-seater van. All festivities and birthdays are celebrated. Residents are encouraged to maintain community links and attend community group activities such as bridge club, library for guest speakers, Ranfurly club and trivia quizzes at other rest homes. Volunteers involved in the activity programme include hostel students, childcare centre children and regular church services.  A resident activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six-monthly. The service receives feedback on activities through one-on-one feedback, resident’s meetings and surveys. Residents interviewed spoke positively about the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six-monthly in three of three resident files reviewed. Two residents had not been at the service six months. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the residents’ files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents’ files.  There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. |
| 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 | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in a locked cupboard. Personal protective clothing is available for staff and was observed being worn by staff that were carrying out their duties on the day of audit. Staff have attended chemical safety training. |
| 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 building has a current building warrant of fitness that expires 10 June 2018. The owner/manager oversees the maintenance and repairs. There is a six-year planned property maintenance schedule in place. Essential contractors are available 24-hours. Electrical testing is completed and annual calibration of clinical equipment is carried out.  There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained and landscaped outdoor areas. Seating and shade is provided. The facility is smoke free.  The caregivers interviewed stated they have sufficient equipment including mobility aids, hi-lo beds, wheelchairs, pressure injury resources (if required), to safely deliver the cares as outlined in the residents’ care plans.  The prospective new owner confirmed on interview there will be no environmental changes (apart from ongoing maintenance made during the first year of ownership). |
| 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 | All resident rooms have hand basins. Two resident rooms have full ensuites and seven rooms have toilet ensuites. There are adequate numbers of communal shower rooms and toilets with privacy locks. Residents confirmed staff respect their privacy while attending to their hygiene cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All rooms are single. There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. |
| 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 | Communal areas within the facility includes a spacious dining area and a large separate main lounge. All furniture is safe and suitable for the residents. Communal areas are easily accessible to residents. |
| 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 | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. Caregivers complete the laundering of personal clothing, sheets and pillowcases. Other linen is collected and delivered by a commercial laundry service. There is a designated laundry with a defined clean/dirty area and external door for pickup of dirty linen. There is a dedicated cleaner on duty Monday to Friday. The cleaners trolley is kept in a locked area when not in use. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. Residents interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | There are policies and procedures on emergency and security situations, including how services will be provided in health, civil defence or other emergencies. Civil defence supplies include 800 litres of stored water and food for 3 days. There is a barbeque and spare gas bottles. There is a civil defence kit in the facility, however, there were items that were past the expiry date. The owner/manager responsible for maintenance completes emergency training for all new employees. Interviews with caregivers confirm staff are aware of emergency and security procedures.  There is an approved fire evacuation plan. Fire evacuation drills are scheduled to be conducted every six-months. A fire evacuation drill was last completed on 26 April 2017 however it was not completed within a six-month period of the previous fire evacuation drill. There is a first aider on duty at all times. Resident’s rooms, communal bathrooms and living areas all have call bells. The call bells ring to panels at each end of the home. Residents are orientated to the call bell system on admission to the facility. Security policies and procedures are documented and implemented by staff. |
| 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 | Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Heat pumps are used in all communal areas that also provide heat in resident bedrooms. All bedrooms have adequate natural light. |
| 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 | The responsibility for infection control is shared between the owner/manager (RN) and a senior caregiver (second in charge). Responsibility for infection control is described in the job descriptions. The infection control coordinators oversee infection control for the facility and are responsible for the collation of infection events. The infection control programme has been reviewed annually.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine. There have been no outbreaks. |
| 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 infection control coordinators have both attended external education. The senior caregiver has attended an infection control study day at the DHB and the owner/manager/RN has attended an outbreak management study day at the DHB. There is access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant and reviewed regularly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinators are responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff complete infection control hand hygiene audits.  Resident education is expected to occur as part of providing daily cares. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinators collate information obtained through surveillance to determine infection control activities and education needs in the facility. The service completes monthly infection rates for types of infections. Infection control events are discussed at the staff meetings, however there is no documented evidence of identified trends or analysis (1.2.3.6).  Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Aversham House has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The RN is the restraint coordinator. On the day of the audit there were no residents on restraints or enablers. The restraint coordinator confirmed that the service promotes a restraint-free environment. Restraint education is included in the two-yearly training programme and last occurred in August 2017. |

# 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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| **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 Moderate | Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The staff meeting minutes do not reflect that these have been routinely discussed and communicated to staff. The meeting schedule had not been followed as per schedule. A resident meeting has recently been commenced as a corrective audit from their previous audit. These are scheduled bi monthly and to date one has been completed. A six-monthly newsletter is provided for residents and relatives. | (i) There was no documented evidence in meeting minutes around quality data, trends analysis and what actions were required by staff.  (ii) The quality/management meetings had not occurred as scheduled. The last staff meeting is scheduled monthly and was last held July 2017. | (i) Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required.  (ii) Ensure meetings occur as scheduled.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is a two-yearly education plan in place that includes all required education as part of these standards. Not all compulsory education had been completed in the two-yearly education plan. | Education not completed within the last two years includes code of rights, complaints/open disclosure, sexuality/intimacy, spirituality/counselling, wound care, skin integrity and pressure area, nutrition/hydration and the aging process. | Ensure staff attend compulsory training as scheduled.  90 days |
| Criterion 1.3.3.3  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. | PA Low | InterRAI assessments have been completed for all residents and they are all currently up to date. Routine interRAI assessments had been completed for three of three resident files who had been at the service six months. InterRAI assessments for two new admissions had not been completed within the required timeframe. One resident did not have a care plan in place following a routine interRAI assessment. | (i) For two recent admissions (in 2017), the interRAI assessments had not been completed within 21 days of admission.  (ii) There was no long-term care plan in place for one resident following a routine interRAI assessment. | (i) Ensure interRAI assessments are completed within 21 days of admission.  (ii) Ensure long-term care plans are place following routine interRAI assessments.  90 days |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Moderate | Fire evacuation drills are scheduled to be conducted every six months. A fire evacuation drill was last completed on 26 April 2017 however it was not completed within the six-month period of the previous fire evacuation drill. There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. There is a civil defence kit in the facility, however there were items that were past the expiry date. | (i) A fire evacuation drill was last completed on 26 April 2017; however, it was not completed within the six-month period of the previous fire evacuation drill completed on 12 June 2016.  (ii) There was no up-to-date civil defence kit checklist. The civil defence kit reviewed had items that were past the expiry date. | (i) Ensure that fire evacuation drills are completed as per the schedule every six months.  (ii) Ensure that there is an up-to-date civil defence kit checklist and that all items are up-to-date.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

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End of the report.