

Scovan Healthcare Limited - Alexander House

Introduction

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

The audit has been conducted by Health 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: Scovan Healthcare Limited

Premises audited: Alexander House

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 5 October 2017 End date: 6 October 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: 18

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
Yellow	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
Red	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

Alexander House rest home is privately owned and operated by experienced owner/managers of ten years. The service is certified to provide rest home level of care for up to 20 residents. On the day of the audit there were 18 residents.

This surveillance audit was conducted against the Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

One of the owner/managers is a registered nurse and responsible for the daily operations of the business and clinical care of the residents. She is supported by a part-time registered nurse and a stable workforce.

Residents and a relative interviewed commented positively on the standard of care and services provided at Alexander House.

Four of four shortfalls identified at the previous certification audit have been addressed around signed job descriptions, essential notifications, documented interventions and three-monthly medication chart reviews.

This surveillance audit identified an improvement is required around reference checking for staff.

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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Alexander House provides care that focuses on the individual resident. Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

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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Alexander House is implementing a quality and risk management system that supports the provision of clinical care. The quality framework includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality data is collated and reported to staff at the bi-monthly staff meetings.

Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly meetings and via annual satisfaction surveys. There is an annual in-service programme that has been implemented for the year and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and caregivers report staffing levels are sufficient to meet resident 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.		Standards applicable to this service fully attained.
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Entry to the service is managed by the owner/manager/registered nurse. There is comprehensive service information available. Initial assessments, care plans and evaluations are completed by the registered nurses. InterRAI assessments are completed for all residents. Care plans are reviewed within the required timeframes. Care plans demonstrate allied health involvement in the care of the resident. Residents confirmed they were involved in the care planning and review process and there was documented evidence that families were involved. General practitioners reviewed residents at least three-monthly or more frequently if needed.

An activity coordinator provides an activity programme that meets the resident's individual recreational preferences. Residents are encouraged to maintain community links.

Medication policies are in line with legislation and guidelines. All staff who administer medications have completed an annual medication competency and medication education.

Meals are prepared on-site. The menu is varied and appropriate. Individual dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

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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The building has a current warrant of fitness.

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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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There were no restraints or enablers in place. Staff have received training in the management of challenging behaviour.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is the registered nurse. There is a suite of infection control policies and guidelines that meet infection control standards. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (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	15	0	1	0	0	0
Criteria	0	40	0	1	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Alexander House has a complaints policy that describes the management of complaints process. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint's register in which verbal and written complaints were documented. There has been one complaint since the 2016 audit. The complaint reviewed had noted investigation, timeframes, corrective actions when required and resolutions. Discussions with residents confirmed that any issues are addressed and they feel comfortable to raise any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accidents/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incident/accident forms reviewed include a section to record family notification. All incident forms reviewed forms indicated family were informed. There was evidence that relatives were notified of any changes in their family member's health status.</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>Alexander House is a 20-bed rest home. On the day of the audit there were 18 residents, all 18 were under the Age-Related Residential Care Services Agreement</p> <p>There is a business plan that includes goals, key objectives, strategic direction and quality improvement and risk management. The service goals are measured regularly through the management (quality) meetings and staff meetings. Alexander House is one of two facilities owned by the two owner/managers for eight years. The service is operated and managed by one of the manager/owners who is a registered nurse experienced in aged care. She is supported by an RN who has been at the facility for 10 years. The part-time RN works eight hours (one day) a week and is flexible to increase hours as required. The RN was not available on the day of the audit. The owner/manager has completed at least eight hours of professional development.</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>	<p>FA</p>	<p>Alexander House has a documented quality assurance and risk management plan in place. The plan includes objectives for the year and methods of measurement. The implemented internal audit programme aligns with the business plan. Audits have a documented action plan as needed which document evidence of follow up and sign off. The service collates accident/incident and infection control data. Quality data is discussed at the six-monthly quality meeting and reported to the bi-monthly staff meetings.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The policies are reviewed two yearly. Staff interviewed (one cook and three caregivers) confirmed they are made aware of any new/reviewed policies and the quality process.</p> <p>Resident/relatives meetings occur monthly (minutes viewed). Four residents interviewed were aware meetings are held.</p> <p>Annual surveys are conducted of residents and relatives (last one September 2017 and action taken on feedback). All residents interviewed stated they are regularly asked for feedback regarding the service. The residents and the relative interviewed spoke positively about all aspects of the service.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>There is an accident/incident reporting policy. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information that is part of the quality framework. Accident/incident forms are collated monthly. Issues and trends are reported to staff via the bi-monthly staff meetings. Management were knowledgeable of the requirement to</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>notify significant events to relevant authorities (lack of notification had been a previous finding). Since the previous audit there had been no events to notify.</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>	<p>PA Low</p>	<p>There are policies and processes to guide practice around recruitment and human resources management. Six staff files were sampled – One registered nurse, the cook, the activities officer and three caregivers. There are job descriptions for all positions that include responsibilities and accountabilities. The previous finding had been corrected. Not all new staff had documented reference checks on file. Professional annual practising certificates are maintained. The service has a training policy and schedule for in-service education and training records are maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is an annual appraisal process in place and appraisals were current in files reviewed.</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>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. The service has a staffing levels policy implemented, which determines that the manager/owner or the RN will be on-call at all times. New staff are rostered on duty with an experienced staff member during the orientation phase of their employment. The manager, RN and activities officer are on duty Monday to Friday. Two caregivers and a cook are on duty each morning, two caregivers in the afternoon and one at night.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are medication policies in place that meet the MOH medication management guidelines. Caregivers and RNs have completed annual medication competencies and attended medication education. All medications are checked by the RN on delivery and any discrepancies fed back to the pharmacy. Standing orders are not used. There were no residents self-medicating on the day of audit. Signing for administration is now undertaken on an electronic system.</p> <p>Ten medication charts reviewed had photographs and allergy status identified on the charts. The previous finding relating to three-monthly medication reviews had been corrected. An electronic medication charting system had been introduced.</p> <p>Ten of ten medication charts had been reviewed three-monthly by the GPs.</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>All meals and baking are cooked on-site. The cooks have completed food safety and hygiene units and chemical safety training.</p> <p>There is a food services manual in place to guide staff. The four-weekly summer/winter menu has been reviewed by a dietitian October 2015 and a request had been forwarded for another review. A resident nutritional profile is developed for each resident on admission. The cook is notified of residents' dietary preferences, including likes and dislikes. Residents interviewed stated their dietary needs are accommodated including alternative options.</p> <p>The temperatures of refrigerators, freezers and cooked foods are monitored and recorded weekly. All food was stored appropriately and dated. The service is currently working towards registration with MPI Food Control.</p> <p>Residents and relatives (survey) commented positively on the quality and variety of food served.</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>FA</p>	<p>When a resident's condition changes the RN initiates a GP visit or nurse specialist consultation. Short-term care plans are developed for the management of short-term needs and changes in a resident's health status. There is evidence of three-monthly medical reviews or earlier for health status changes. There is evidence of relative notification of health status changes as documented on the family communication form.</p> <p>Staff have access to sufficient medical and dressing supplies. On the day of audit, supplies of these products were sighted. There were no wounds on the day of audit. There were no pressure injuries. A wound management plan, evaluation and wound monitoring forms were evidenced for the last wound that a resident had.</p> <p>The manager interviewed could describe the referral process to specialist nurses available through the DHB.</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</p>	<p>FA</p>	<p>The service has recently appointed a new activities officer increasing the hours to 25 per week Monday to Friday. She is currently undertaking level 4 qualifications. The activity coordinator attends monthly local diversional therapy meetings and all on-site education. The weekly programme includes a variety of activities that meets the recreational preferences and abilities of the residents. Residents were observed participating in activities throughout the audit day.</p> <p>There are entertainers, weekly visiting canine friends, weekly van outings and fortnightly church services. Residents are encouraged to maintain community links with activities such as shopping, café visits and attending community clubs and involvement with residents from other local rest homes.</p>

of the service.		Resident meetings provide residents with an opportunity to provide feedback on the activity programme. Residents and the relative interviewed commented positively on the wide variety and options for activities The activity plans were reviewed at the same time as the clinical care plans in resident files sampled.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	There was evidence initial care plans are evaluated within three weeks and long-term care plans evaluated six-monthly. There were written evaluations that evidenced multidisciplinary input into the review process. The GP reviews the resident at least a three-monthly. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing.
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 holds a current warrant of fitness which expires on 8 July 2019.
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 coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Individual infection forms are completed for all infections. Infections are included in a monthly summary and are discussed at both the staff and quality meetings. Staff interviewed were aware of infection rates and infection control practice. Internal audits for infection control are included in the annual audit schedule. The infection control nurse specialist at the DHB is readily available and the DHB facilitates the benchmarking of infection rates amongst providers. Systems are in place and are appropriate to the size and complexity of the facility. There have been no outbreaks since 2014.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is	FA	Alexander House rest home has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The owner/RN is the restraint coordinator with a job description defining responsibilities of the role. The restraint coordinator confirmed the service promotes a restraint-free environment. There were no residents assessed as requiring restraint or enablers. Challenging behaviour and restraint minimisation and safe practice education has been provided.

actively minimised.		The caregivers interviewed were knowledgeable in the use of enablers/restraint.
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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 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Six staff files were sampled. Appointment/recruitment documentation was seen on staff files including signed contracts, orientation and training.	There was no evidence that reference checking had occurred for two of two recently employed staff members.	Ensure that evidence of appropriate reference checking is maintained. 90 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, 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.