

Experion Care NZ Limited - Albany House Rest Home and Hospital

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 Q-Audit 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:	Experion Care NZ Limited
Premises audited:	Albany House Rest Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 July 2020 End date: 3 July 2020
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:	24

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

Albany House provides rest home and hospital level care (medical and geriatric) for up to 25 residents. and is certified to provide rest home and hospital level of care. There were 24 residents at the facility on the first day of the audit. The nurse manager has been running the service since 2004.

The prospective owners are in the process of completing the requirements for owning the service. The prospective owners have experience in the health sector. There are no intentions to change existing service delivery or environment should the sale of the service be confirmed.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. A change of ownership is anticipated to occur on 19th August 2020. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

There were eight areas identified as requiring improvement. Improvements are required to the following, evaluation of action plans, human relation employment practices, cleaning chemicals, spill kits, storage oxygen cylinders, fire evacuations, medication management, resident activity plans and resident menu plans.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

There is a documented and implemented complaints management system. The administration manager is responsible for managing complaints.

Organisational management

Albany house has been caring for the elderly since 2004, servicing residents wanting a home like environment. The service is managed by the owner/manager who is appropriately qualified. The business plan documents the organisations goals and objectives. The quality and risk management system includes collection and analysis of quality improvement data and identifies

trends. Reporting processes are in place. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and current annual practising certificates are kept on file.

Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Residents are assessed prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service is provided onsite and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan was in place.

Safe and appropriate environment

Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in the use of emergency equipment and supplies. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint and three were using enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in restraint, challenging behaviours and de-escalation techniques through in-service training.

Infection prevention and control

The infection prevention and control management system is in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	38	0	4	3	0	0
Criteria	0	85	0	5	3	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>Albany House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form and signed by the resident or when appropriate signed by the enduring power of attorney (EPOA).</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to</p>

		consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
<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>	FA	Residents confirmed they were aware of the process to access the nationwide Health Disability Advocacy service. During the admission process, residents are given a copy of the Code, which also includes information on Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.
<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>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>There have been no complaints received from external sources since the previous audit. The administration manager (AM) is the complaints officer. The AM explained the process should a complaint be received this included the actions to be taken, through to an agreed resolution, are documented and completed within the timeframes. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff on admission. The Code is displayed in the reception area together with information on advocacy services, how to make a complaint form.</p> <p>The prospective owner confirmed via email their understanding of the code. The prospective owner currently operates five rest home facilities within New Zealand. Residents rights are noted on the business register to ensure ongoing reporting and management.</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>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. The nurses' station is located in the residents dining room. All resident's information is located, in a locked cupboard in the same area. Staff interviewed understood the need to ensure residents files and information, including verbal was undertaken in a private manner.</p> <p>All residents have a private room. The nurse manager interviewed stated there is the ability to share rooms with a spouse with their consent.</p> <p>Residents are encouraged to maintain their independence by participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>	<p>FA</p>	<p>The service has one resident who identifies as Māori. relation to information about Māori beliefs. Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori resident whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</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>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences and required interventions were included in care plans reviewed, such as church services. The resident meeting minutes confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Staff job descriptions and the induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through, evidence-based policies, input from external specialist services and the comprehensive education schedule. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p>

		<p>An example of good practice stated at audit was the facilities recent response to the national Covid 19 response. The facility was divided into three section bubbles. With residents and where possible staff maintained within their bubble. Each bubble had a separate dining and lounge area. To date no resident had been reported to have contracted Covid 19. The facility maintains vigilance including tracking each visitor to ensure good infection prevention and control practices.</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>Residents and family members stated they were kept well informed about any changes to their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Resident meeting minutes reviewed evidenced relevant information is shared and concerns acted upon in a timely manner.</p> <p>Staff interviewed confirmed the process on how to access interpreter services. Interpreter services can be accessed via the district health board (DHB) or interpreting New Zealand when required. Staff reported this is rarely required.</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>	FA	<p>The service is up for sale and the prospective owners have commissioned a provisional audit. Albany House is potentially to be purchased by the new prospective owners. The prospective owners have an established structure outlined in their business plan. The prospective owners currently own and manage five rest homes facilities with a total of 180 beds within New Zealand. The prospective owners 2018-2021 business plan was sighted.</p> <p>The transition plan includes how the prospective owners will be transitioning the running of the current and management of the service under the support of the current owners. The prospective owner's intention is to retain the current service as it is including all staff. Future changes will be considered on a need basis and the retirement of the</p>

		<p>current owners. The planned settlement date is 19th August 2020. The prospective owner and the current owners report that the planned transition time will be for a period of six months or more if required.</p> <p>The prospective owner has five other rest home within New Zealand and intends to manage this service in the same manner. Reporting structure that was establish in 2015. This includes reporting of key performance indicators such as incident/accidents, wound management, restraint and complaints.</p> <p>The facility is currently owned by a husband and wife partnership. The service is managed by the wife who is a New Zealand registered nurse and is supported by an administration manager. There is a registered nurse (RN) onsite covering each shift, with the nurse manager (NM) or another allocated RN on call. All members of the management team are suitably qualified and maintain professional qualifications and responsibilities defined in the job description and individual employment agreements.</p> <p>The service holds contracts with the district health board and ministry of health for rest home, hospital level care long term support chronic health conditions and palliative care. There were 24 residents receiving service on the day of audit. Comprising 14 rest home and eight hospital level care. There were two residents under long term chronic illness contract one of who was under 65 years of age.</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>	<p>FA</p>	<p>When the NM is absent, the RN allocated to the role carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by RN on the shift who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>The prospective owner reported that they will maintain the current plan, with a RN who is currently on maternity leave covering the clinical role when returning.</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>PA Low</p>	<p>The organisation uses an external providers quality and risk management system that reflects the principles of continuous quality improvement this includes management of incidents/accidents and audit activities.</p> <p>Service delivery is monitored through complaints, review of incidents/accidents, audit schedule and resident and staff satisfaction surveys. The audit schedule, action plans opened, and resident and staff surveys completed were not consistently documented to allow for collation and analysis of data.</p> <p>Facility meetings are conducted, and comprehensive minutes evidenced communication with staff around all aspects of quality improvement and risk management. Staff reported that they are kept informed of quality improvements, such as audit activities and areas of risk such as Covid-19.</p> <p>Albany House has a risk management programme in place. Health and safety policies and procedures are documented along with hazard management programme. There is evidence of hazard identification forms completed when a hazard was identified and that hazards are addressed, and risks minimised. The Health and safety officer is new (refer 1.2.7.3) and is yet to receive training. The NM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>Policies and procedures are provided by an external provider and cover all aspects of the service. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The prospective owner confirmed the existing policies and procedures will remain as other facilities within the same group use the same external contractor.</p> <p>An improvement is required regarding the management of the quality improvement programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>Staff understood the adverse event reporting process and were able to describe the importance of reporting near misses. Staff are</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>		<p>documenting unplanned or untoward events on an accident/incident forms and are completed by staff who are either witnessed and adverse event or were first respond. The RN undertake assessments following an accident. Neurological observations and risk assessments are completed following accidents/incidents as appropriate.</p> <p>Policy and procedures comply with essential notification reporting, for example health and safety, human resources and infection prevention and control. The NM and administration manager is aware of situations in which the service would need to report and notify statutory authorities</p> <p>Including police attending the facilities, unexpected deaths, sentinel events, notifications of a pressure injury, infectious disease outbreaks, and changes in key clinical managers.</p> <p>The prospective owner understands their statutory and /or regulatory obligations in relation to essential notification reporting and to notify correct authority where required.</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 Moderate</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of staff files reviewed (three employed in the past six months and three employed over two years) indicated the organisation's policies and procedures were not consistently implemented and records maintained.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificate and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that require them.</p> <p>Staff orientation includes all necessary components relevant to the role. Carer staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB Care givers are paired with a senior care giver or RN until they demonstrate competency on specific tasks for example hand hygiene, moving and handling. Staff reported that the orientation process prepared them well for their role.</p>

		<p>Albany house has a documented comprehensive education schedule. This was not currently up to date related to the national Covid-19 levels. The NM and administration manager reported planning is under way to re commence the programme now at level 1.</p> <p>There were three RN's that were interRAI competent.</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>Staffing rosters were sighted and one RN is on each shift, which meets the documented rationale for staffing at the service. The NM is always available and onsite 40 or more hours a week. The facility adjusts staffing levels to meet the changing needs of residents. Carer staff reported there were adequate staff available to complete the work allocated to them.</p> <p>Staff and residents interviewed confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time. The roster evidenced an increase in staffing to meet residents needs when necessary, such as Covid-19.</p>
<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>All resident files are in hard copy and stored in the secured in the locked cupboard in the patients dining area. Entries are legible, dated and signed by the relevant staff member including designation. Individual residents' files demonstrate service integration. 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.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Albany House's welcome pack</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>		<p>contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</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>	<p>FA</p>	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</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>PA Low</p>	<p>There were no residents who self-administer medication and self-administration policies and procedures are in place if required. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner</p> <p>An annual medication competency questionnaire is completed by all staff administering medications and medication training records were sighted. Medication audits were completed, and all corrective actions rectified.</p> <p>An improvement is required to ensure six monthly controlled drugs (CD) stock takes and practical medication competencies are completed. Staff medication competencies were signed off by a staff with no current medication administration competency.</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</p>	<p>PA Low</p>	<p>Meal services are prepared on site and served in dining rooms. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and</p>

<p>where this service is a component of service delivery.</p>		<p>drinks are available for residents when required.</p> <p>Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.</p> <p>Timely review of menu by the registered dietitian could be improved.</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 nurse manager reported that all residents who are declined entry are noted. When a resident is declined entry, family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.</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>Residents have their level of care identified through needs assessment by the assessment agency. Initial nursing assessments are completed within the required time frame on admission while residents' care plans and interRAI assessments are completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whanau, residents and other health team members as appropriate. Additional assessments are completed according to the need and these included pain, behavioural, falls risk, nutritional requirements, continence, skin and pressure assessments. The nursing staff utilised standardised risk assessment tools on admission. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.</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 assessment findings inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans are used for short-term needs. Family/whanau and residents interviewed confirmed they are involved in the care</p>

		planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, district nurses, physiotherapist, podiatrist, speech language therapist, dietitian and GP.
<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>	FA	<p>Interventions are adequate to address the identified needs in the care plans. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.</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>	PA Low	<p>The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</p> <p>An improvement is required to ensure all residents have activities care plans in place.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses complete progress notes daily and as necessary. All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals is completed however, some residents' files reviewed had no current activities care plans in place (Refer 1.3.7.1). The evaluations are carried out by the RNs in conjunction with family, GP and specialist service providers. Where progress is different from</p>

		<p>expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</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>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers when required. If the need for other non-urgent services are indicated or requested, the GP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required.</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>	PA Moderate	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available.</p> <p>Review of staff training records and interviews with carer, household staff confirmed that regular training and education on the safe and appropriate handling of chemicals and waste and hazardous substances occurs (Refer 1.2.). An improvement is required around on-site chemical storage and use.</p> <p>A hazard register and maintenance plan are in place.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	FA	<p>A building warrant of fitness (expiry date June 2020, issued August 2019) is publicly displayed. The administration manager reported the</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>external company is behind issuing new certificates, this is related to Covid-19 level 4. The facilities were observed to be in good condition, light, well ventilated, appropriate and suitable for the needs of residents, with safe external areas. Residents can walk around freely throughout the facility and grounds. Residents stated the home is comfortable and appropriate for their needs.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>Hot water temperatures are recorded regularly and were at or below recommended maximum 45@(degrees).</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 hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchair and mobility scooters when required.</p>
<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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. The residents dining room is shared as the nurses' station (refer 1.1.3.) Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>

<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>	<p>FA</p>	<p>Cleaning chemicals are securely stored in locked cupboards (refer 1.4.1) and are labelled. Current material safety data sheets about each product are located with the chemicals in the household cleaner's cupboard and laundry area. The household cleaners' trolley is stored in a locked room when not in use.</p> <p>There is a laundry with a clean and dirty flow. Household staff are responsible for laundry and cleaning services.</p> <p>Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. Training and fire evacuation required under health and safety is yet to occur. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time by staff.</p> <p>An improvement is required for the storage of oxygen cylinders.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>appropriately. Rooms have natural light, opening external windows and a small handbasin.</p> <p>Albany house has adequate heating. Individual bedrooms are heated with adjustable heating panels. Common areas with night stores. The owner (maintenance person) interviewed ensures the heating systems are running smoothly and that appropriate checks are performed. On the days of audit, the indoor temperature was comfortable.</p> <p>Residents and families confirmed the facilities are maintained at a comfortable temperature during the summer and winter months.</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>	<p>FA</p>	<p>The infection control programme is reviewed annually and is incorporated into the review of the education programme. The programme is evaluated to assess the progress in achieving the goals and objectives. The infection control co-ordinator reports to the staff and nurse manager on all aspects of infection prevention and control. Infection control is a standard agenda item at the monthly staff meetings.</p> <p>There are processes in place to prevent staff and residents exposing others when they are unwell. Staff are encouraged not to come to work if they are unwell. There are processes in place to isolate infectious residents if this is required. There are notices on the doors to advise visitors not to visit if they are unwell. Sanitising hand gel is available at all entrances.</p> <p>The roles and responsibility for the infection control coordinator is defined in their position description but there was no signed copy in file (Refer 1.2.7.3). Staff interviewed knew that they are required to report residents who are suspected of having infections to the RNs promptly. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff were able to identify the importance of hand hygiene and using standard precautions.</p> <p>Covid-19 information is shared and accessible to all staff to read. Residents are closely monitored for any signs and symptoms. Personal Protective Equipment (PPE) stock was sighted.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control.</p> <p>Additional support and information is accessed from the infection control team at the DHB and the GP as required. The infection control coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.</p>
<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>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. The infection control coordinator completed infection prevention and control online training (Covid-19 swabbing and PPE on 4 May 2020) to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets current best practice and guidelines. External contact resources included the GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>

<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 programme.</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The organisation's policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers for Albany House staff. Staff reported the facility is restraint free. The restraint coordinator provides support and oversight for enabler and restraint management and demonstrated a sound understanding of the organisation's policies, procedures and practice and his role and responsibilities.</p> <p>On the audit days, no residents were using restraints and three were using enablers, which staff are aware must be the least restrictive and used voluntarily at a resident's request.</p> <p>The restraint coordinator described that restraint can be used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment.</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)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The requirements for a quality and risk management system and the implementation is understood management.</p> <p>An internal audit schedule outlines which and when the audits are to occur and discussed at staff meetings. However, there was no documented evidence the audits had occurred.</p> <p>Incidents/accidents are collated and analysed with action plans opened if required. Data is reported at staff meetings including actions required however, there was no evidence to confirm actions taken were evaluated as to their effectiveness.</p> <p>Residents hold monthly meetings, with</p>	<p>Completed action plans do not evidence actions undertaken are evaluated to ensure the actions undertaken are effective.</p> <p>There is no documented evidence that audits are completed as per the plan.</p> <p>Resident and staff surveys had been completed in the past 12 months, however there was no documented evidence these had been completed.</p>	<p>Ensure all audits, action plans and satisfaction surveys undertaken are documented and evaluated in a timely manner.</p> <p>180 days</p>

		meeting minutes disturbed to all residents. Sighted at audit. Resident and staff surveys are planned to occur, there was no documented evidence to confirm this had occurred.		
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Human resources management policies and procedures are based on good employment practices and relevant legislation. However, there are inconsistencies in the required documentation of human resources, to ensure all documentation and practices align with legislation and good employment practices.</p>	<p>Six staff records were reviewed, this consisted of three employees employed over a two-year period and three new employees. Records reviewed of two staff who had been employed more than two years demonstrated that an annual performance appraisal had not been completed in the past two years.</p> <p>No police checks had been completed for staff members when required.</p> <p>The NM had a current first aid certificate. There was no documented evidence that other staff members that are required to do so, had a current first aid certificate.</p> <p>Neither the infection prevention coordinator or the health and safety officer have a signed position description in their file.</p> <p>There was no evidence that the newly appointed health and safety officer training, is planned.</p>	<p>Ensure all employment practices align with current legislation and good practice.</p> <p>60 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>The medication management system is implemented to ensure that residents receive medicines in a safe and timely manner. Three monthly medication reviews are completed by the GP as required. Discontinued medications are signed and dated by the GP. Allergies are clearly documented; photos are current and three-monthly reviews are completed. Medication charts are legibly written. The caregiver was observed administering medications safely and correctly. The medication and associated documentation are stored safely, and medication reconciliation is conducted by RNs when resident is transferred back to service. The service uses pre-packaged packs which are checked by the RN on delivery. The medication room temperature was being monitored and within normal ranges.</p> <p>Weekly CD stock takes are conducted and all medications are stored appropriately however six-monthly controlled drug stock takes were not being completed.</p>	<p>Six-monthly CD stock takes were not being completed.</p>	<p>Ensure six monthly CD stock take are completed according to policy and legislation requirements.</p> <p>60 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Low</p>	<p>Staff administering medication are assessed as competent. Annual medication competencies are conducted in form of questionnaires and training records were sighted. However, there was no evidence of practical medication competencies records sighted for all staff and the person signing off medication competencies has not been signed off as</p>	<p>Practical medication competencies of staff administering medication were not verified and the person signing off medication competency did not have a current medication competency.</p>	<p>Ensure practical medication assessments are included in the annual competency programme and competencies are signed off by nurses with current</p>

		competent to do so.		competencies. 60 days
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>The kitchen was registered under the food control plan. There is a four weekly seasonal rotating menu in use. Diets are modified as required and the cooks confirmed awareness on dietary needs of the residents. Alternative meal options are offered as required however, there was no evidence to confirm that the menu was reviewed by a registered dietitian.</p>	<p>The menu has not been reviewed by the registered dietitian in the last two years.</p>	<p>Ensure menu is reviewed every two years to comply with recognised nutritional guidelines.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The activities provided are individualised to be meaningful for residents under 65, rest home and hospital level of care. The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. A resident's activities profile is completed within two weeks of admission in consultation with the family and residents where able. The activities are conducted by the activities coordinator covering both the rest home and hospital residents.</p> <p>Some files reviewed had no current activities care plans in place.</p>	<p>Two out of five residents' files reviewed did not have current activities care plans in place.</p>	<p>Provide documented evidence that all residents' have current activities care plans in place.</p> <p>60 days</p>

<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	<p>PA Moderate</p>	<p>Policies and procedures document the process for handling and processing all chemicals, with an external contractor managing and ensuring all material safety data sheets are current and appropriate.</p> <p>Household staff dispense cleaning chemicals into separate containers as per the manufacturer's instructions. However, six of nine separate containers were not labelled as to the contents.</p> <p>No spill kit was available.</p>	<p>Cleaning chemicals dispensed into separate containers were not labelled and no spill kit was available.</p>	<p>Ensure all chemicals that are dispensed into a separate container are labelled as to contents.</p> <p>Ensure a spill kit is available.</p> <p>30 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Moderate</p>	<p>Fire evacuations are included in the annual education schedule to occur twice a year, in January and July. Fire evacuations were last completed July 2019, with the number of staff present recorded, however there was no documented evidence all staff have attended fire evacuation training since July 2019.</p> <p>The facility has two oxygen cylinders which are stored in the linen room; however, these are not secured.</p>	<p>There was no documented evidence fire evacuation training had occurred since July 2019.</p> <p>Oxygen cylinders are not secured.</p>	<p>Complete the six-monthly fire evacuations as per the annual education plan.</p> <p>Ensure all oxygen cylinders are stored in a secure manner as per legislation.</p> <p>30 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.