

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 BSI Group New Zealand Ltd, 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: 28 January 2021 End date: 29 January 2021

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: 20

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Alexander House is privately owned. The service is certified to provide rest home care for up to 20 residents. There were 20 residents on the day of audit.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services Standards and the contract with the district health board. The 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.

The service is managed by an experienced nurse. An additional registered nurse and care staff support the manager. Alexander House has a quality and risk management system in place. Residents and families interviewed were complimentary of the care and support provided.

The previous certification audit did not identify any areas requiring improvement.

This audit has identified one area requiring improvement around care plan documentation.

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.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

There is a business plan with goals for the service that has been regularly reviewed. Alexander House has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is an information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans demonstrate service integration. Residents and family members interviewed confirmed they were involved in the care plan process and review. Care plans are updated when there are changes in health status. Resident files are integrated and include notes by the GP and allied health professionals. The general practitioner completes an admission assessment, visits and reviews the residents at least three-monthly.

An activities staff member facilitates the activities programme. The programme is resident-focused and provides group and individual activities planned around everyday activities. Each resident has an individualised plan. Community activities are encouraged, and van outings are arranged on a regular basis.

There are medicine management policies and procedures in place that reflect legislative requirements. Medication is managed using an electronic medication management system. The medication charts are reviewed by the GP or nurse practitioners three-monthly. All staff responsible for administration of medicines had completed education and medication competencies.

A dietitian has reviewed the menu. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food provided.

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.

The building has a current warrant of fitness. There are sufficient bathroom facilities to meet the needs of residents. Internal and external areas are safe and easily accessible for residents and family members.

The building, plant and equipment comply with legislation. There is a preventative maintenance schedule in place. Chemicals are stored safely throughout the facility and there is appropriate protective equipment and clothing for staff. There are policies in place for emergency management. The facility has civil defence supplies.

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.

Alexander House has restraint minimisation and safe practice policies and procedures in place. There were no residents requiring the use of a restraint or enabler. Staff receive training around restraint minimisation.

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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available at the service entrance. Information about complaints is provided on admission. Interviews with residents and relatives confirmed an understanding of the complaints process. A complaint register includes written and verbal complaints, dates and actions taken. There were no complaints for 2019 and three 2020-2021 year to date. The manager, (who commenced November 2019) was concerned regarding the lack of feedback to the service. An email was sent to all family members and also on social media regarding the complaints process. The manager feels that this intervention has empowered families to provide feedback, which assists service improvement.</p> <p>A review of the complaints register evidenced that the appropriate actions have been taken and the complainant received documented outcome of the complaint. There is evidence of lodged complaints being discussed in quality/management and staff meetings with additional education provided as needed.</p>
Standard 1.1.9: Communication Service providers communicate effectively	FA	<p>There is a policy to guide staff on the process around open disclosure. The facility manager confirmed family are kept informed. One relative interviewed complimented the service regarding the open communication and ease of access to the manager. The relative confirmed that they are notified promptly of any incidents/accidents. Five residents interviewed discussed the regular resident meetings and said that they feel that they are part of the service. Residents/relatives have the opportunity to feedback on service delivery</p>

with consumers and provide an environment conducive to effective communication.		<p>through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as 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>Alexander House is a privately owned service. The home is managed by an experienced registered nurse (RN) who has a master's in nursing and who has been in the role since November 2019. The manager is supported in her role by a part time RN. The owner (also an experienced RN) visits often and is involved in the day to day running of the service.</p> <p>Alexander House is a 20-bed rest home. On the day of the audit, there were 20 residents (including one respite resident). All other residents are under the age-related residential care (ARRC) agreement.</p> <p>The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business and the inclusion of adding hospital services. The service has quality goals, which have been reviewed regularly.</p> <p>The manager has completed at least eight hours of professional development related to managing a rest home.</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>	FA	<p>Alexander House has a well-established and comprehensive quality and risk programme.</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. Staff (two caregivers, one cook, one kitchen manager and one diversional therapist) confirmed they are made aware of any new/reviewed policies.</p> <p>Four-monthly quality meeting minutes and monthly staff meeting minutes sighted evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions. Monthly staff meetings alternate monthly between resident care reviews and training. Annual resident surveys are completed, with the 2020 survey evidencing a high level of satisfaction.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A three-monthly summary of internal audit outcomes is provided to the quality meetings for discussion. Corrective actions are developed, implemented and signed off.</p>

		<p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms were reviewed. All document timely RN review and follow-up. Neurological observation forms were documented and completed for one unwitnessed fall with a potential head injury but not according to timeframes in the policy (link 1.3.6.1). Discussions with the manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications, including section 31 notifications. There have been no notifications lodged since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. The register of RNs' practising certificates and allied health professionals is current. Five staff files were reviewed (one RN, three caregivers and one diversional therapist). All files contained relevant employment documentation including current performance appraisals and completed orientations. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. The service has also completed a wide range of additional training (toolbox talks) such as customer care and medication updates as examples. These have been in response to issues raised and incidents. Staff are supported with external education: four caregivers have achieved level three Careerforce and seven level two. Students from Horizons training also undertake work experience at the service.</p> <p>Both the manager and RN have completed interRAI training.</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>Alexander House has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs, on different shifts. The manager is on site during the day Monday to Friday and is on-call 24/7. There is a part-time RN who works on Tuesday and Wednesday and assists with on call.</p> <p>At the time of the audit, there were 20 rest home residents. There are two caregivers (one shares caregiving and housekeeping duties) on the morning and afternoon shifts and one caregiver on the night shift. Residents and relatives stated there were adequate staff on duty. Staff stated they feel supported by the manager and RN who respond quickly to after-hour calls.</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>	FA	<p>The facility utilises a computerised medication management system. The registered nurse reconciles the packaged medication against the individual resident electronic medication charts on delivery. Ten medication chart signing sheets were reviewed (including a respite resident) and reflected medications were administered as prescribed. Medications have been reviewed three-monthly with medical reviews by the attending GP with the pharmacist.</p> <p>All 'as required' (PRN) medications had been administered as prescribed including reason for administration and efficacy documented. Resident photos and documented allergies or 'nil known' were documented on all ten medication charts reviewed. An annual medication administration competency was completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There were no residents who self-administered medications.</p> <p>No vaccines were stored on site.</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>	FA	<p>All meals at Alexander House are prepared and cooked on site. There is a four-weekly rotating menu, which was in the process of review by a dietitian. The food control plan was verified 30 September 2020 for 18 months.</p> <p>Meals are prepared in the kitchen adjacent to the rest home dining room and served directly to residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurses. Weights are monitored monthly or more frequently if required and as directed. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. Fridge and freezer temperatures are monitored and recorded daily. On the day of audit, it</p>

		was observed that tea, coffee, and snacks were always freely available to all residents.
<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>	PA Low	<p>RNs will initiate a referral, if external nursing or allied health advice is required. Caregivers follow the care plans and report progress against the care plan each shift. Care plan did not all document all care needs (noting that all staff were well informed regarding resident care needs). Staff have access to sufficient medical supplies including dressings.</p> <p>Continence products are available and resident files include bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed stated there is adequate continence and wound care supplies. There were no residents with wounds at the time of audit.</p> <p>Caregivers reported that a range of equipment was readily available as needed including hoists and manual handling equipment. Monitoring charts examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required, not all neurological observations were according to policy.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs a diversional therapist (DT) who works 25 hours a week Monday to Friday. The two-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>Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.</p> <p>Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available in the lounge, on notice boards, and in each resident's room. The group programme includes residents being involved within the community with social clubs, churches and schools.</p> <p>The diversional therapist interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed monthly.</p>

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is reviewed at least six-monthly or earlier if there is a change in health status. Evaluations document progress toward goals. There is at least a three-monthly review by the GP or nurse practitioner. Changes in health status are documented and followed up. Care plan reviews are signed by an RN. Where progress is different from expected, the service responds by initiating changes to the care plan.
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 warrant of fitness. All equipment has been recently calibrated, tagged and tested. There is a preventative maintenance schedule in place. Hot water temperatures are checked monthly and are within safe parameters. If there are concerns, corrective actions are implemented. Outdoor areas are easily accessible for rest home residents.
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	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.</p> <p>The infection control policy has been updated to reflect Covid-19. All lockdown stages have been included in the policy. During lockdown the service provided additional education for staff and ensured all regulated procedures such as staff and resident screening, and stopping all visitors were in place.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Alexander House has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint free environment. Staff receive training around restraint minimisation.

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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Five resident files (including a respite resident) were reviewed for this audit. All care plans were up to date. Handovers ensure that all staff are aware of resident needs and caregivers were observed providing a high-level care and were able to explain resident's care needs. Care plans did not always document all care needs. The risk has been defined as low due to the high level of caregivers' knowledge.</p>	<p>i) Two post falls neurological observations were not according to service policy timeframes.</p> <p>ii) Care interventions for Māori culture and confusion were not documented in one resident care plan.</p> <p>iii) Recognition and treatment for</p>	<p>i) Ensure that neurological observations are documented according to policy.</p> <p>ii) – iv) Ensure that all known risks and care interventions are documented in residents care plans.</p>

			<p>seizures (one care plan) and chest pain (one care plan) were not documented.</p> <p>iv) The risks associated with anticoagulant therapy and insulin use were not documented (one care plan).</p>	60 days
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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.