

Ambridge Rose Villa Limited - Ambridge Rose Villa

Introduction

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

The audit has been conducted by 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:	Ambridge Rose Villa Limited
Premises audited:	Ambridge Rose Villa
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 December 2018 End date: 5 December 2018
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:	27

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

Ambridge Rose Villa provides rest home level care for up to 31 residents. The service is operated by Ambridge Rose Villa Limited and managed by a facility manager who is supported by a chief operating officer. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's Aged Care contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations on site and interviews with residents, family management, staff and a general practitioner. There have been no changes to the organisation since the last audit.

This audit resulted in no identified areas requiring improvement.

Consumer rights

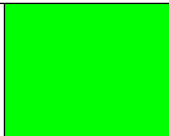
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Resident rights are maintained in line with consumer rights legislation. All residents and families are informed of their rights on admission, including the informed consent processes and access to advocacy services. Families and residents are encouraged to appoint an enduring power of attorney. Interpreting services are available if needed. Privacy, confidentiality, individual cultural values and beliefs are supported and respected. There are processes for the identification, reporting and management of any suspected discrimination or abuse/neglect. Services are provided in line with current good practice principals. There is a documented open disclosure process and family/next of kin are notified of any adverse event that occurs. Families interviewed stated that they are fully informed at all times.

The complaints procedure is provided and explained to family as part of the admission process. The complaints process is managed in line with complaints legislation. There have been no complaints made since the last audit. Families interviewed stated that any concerns are acknowledged and addressed promptly. Open communication between staff, residents and families promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The chief operating officer (COO) is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

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.
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The governing body is responsible for the service provided. A business plan and quality and risk management plan are documented and include the scope, direction, goals, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular reporting by the facility manager to the governing body.

The facility manager is an experienced and suitably qualified registered nurse/manager. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of any complaints and incidents, health and safety,

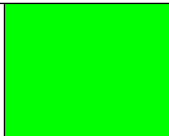
infection control, restraint minimisation and resident/representative/family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported with discussion of any trends and follow-up where necessary. Adverse events are documented and are seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Any feedback is used to improve services. Risks are identified and management strategies in place. The hazard register is up to date.

A suite of policies and procedures based on current good practice cover all aspects of service delivery, are current and reviewed regularly.

The human resources management policy is in accord with current legislation and guides the system for recruitment and appointment of staff. An orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan facilitate and record ongoing training supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster for staff to contact senior personal for afterhours if needed.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Assessments and care plans are completed and evaluated by the nursing team. Activities plans are completed by the facility manager (FM) in consultation with the activities coordinators. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, family/whanau expressed satisfaction with the activities programme in place.

Medications are managed and administered in line with the medication management policy. Medications are monitored and reviewed as required by the general practitioner (GP). The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The environment and building are fit for the care of residents at rest home level. The building has a current warrant of fitness and current approved evacuation plan. Maintenance requirements are met.

Clinical and household equipment and furnishings are in good order and sufficient for the number of residents. Functional, electrical and calibration checks are up to date. The facility has adequate communal areas to meet the residents' needs. There are 29 single bedrooms and one twin room, each with own hand basin. There are sufficient numbers of toilets and bathing facilities in the adjacent areas. Lights and call bells are installed in each bed space and bathrooms. Emergency procedures and equipment are provided. Family/whanau reported they felt their family member was safe and secure. Cleaning, waste management and laundry areas are secure. Processes comply with regulations and are monitored.

The outdoor areas are level and secure. Pathways used by residents are paved. There is a current building warrant of fitness in place. There have been no changes to the layout of the facility since the last audit.

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.

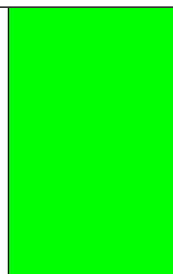


Standards applicable to this service fully attained.

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in the management of challenging behaviours. There is a security gate at the entrance of the service with codes displayed and accessible to residents and family/whanau.

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 is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff and visitors. The infection control coordinator (ICC) is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There was no infection outbreak reported since the last audit.

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	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health Consumer Code of Rights (the Code) is displayed. Residents and staff have a pocket size personal copy. Staff undertake training regarding consumer rights provided through Altura e-learning during orientation and in ongoing education. In interview, staff were able to describe how they incorporated resident rights into their day to day practice. Resident / family surveys indicated that families are satisfied that the residents rights are respected.</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>The informed consent policy includes guidelines for informed consent, resuscitation protocols, enduring powers of attorney (EPOAs), advanced directives and end of life care plans. Residents and families interviewed indicated that they received full information and explanations about any decisions and choices related to the resident. Residents' files sampled had consent forms signed by the resident or EPOA. The files contained notes regarding the resident's wishes for end of life care if known. Example sighted of a palliative care plan that includes directives about the resident and family wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them.</p> <p>Requirements for written consent are clearly defined and include photographs, display of residents' name, annual flu vaccination, minor surgical procedures, sharing resident information with family and transport in the van on outings. The FM is responsible for ensuring that the resident/family have all the</p>

		<p>information they need to be informed before giving or withdrawing consent. Staff receive training about informed consent in their care of residents during induction and as part of the annual training program.</p> <p>There is a detailed policy about EPOAs. Relatives are encouraged to prepare one ready for activation when required. Copies are kept in the resident's file. Staff training is provided biannually or more often if requirements change.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and family/whanau reported that they are provided with information regarding access to advocacy services. Families are encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service are listed in the resident information booklet and pamphlets are available in the entrance hall. Education on advocacy and support is conducted as part of the in-service education programme.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and relatives are encouraged to visit at any time. Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community activities and services such as weekly community social groups, church services, volunteering at community agencies, family visiting and events, croquet, shopping at the local plaza, with visitors or as part of the planned activities programme.</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. There is also a complaints flow chart to guide staff. The information is provided to residents on admission and there are complaints information and forms available at reception.</p> <p>The complaints register sampled showed that seven complaints have been received since August 2015. The register records name, date received, persons handling the complaint, date action to be taken, date completed and involvement of an advocate. One involved an advocate, records reviewed indicated a supportive process with a satisfactory outcome. Records of another example about resident care were reviewed and indicated that the issues had been acknowledged and appropriately addressed. An agreed resolution was achieved and completed within the timeframes specified in the Code. Action plans sampled show any required follow up and improvements have been made where possible. One complaint was taken further to the Health and Disability Commissioner; records of appropriate and timely response were sighted.</p> <p>The COO is responsible for complaints management and follow-up. 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>	FA	<p>Information about consumer rights legislation, advocacy services and the complaints process is provided on admission and displayed in the entrance hall. The Code of Rights is available in Maori and English. respectively. Residents and families interviewed were aware of their rights and confirmed that information was provided to them during the admission process. The rest home 's information pack includes information about the availability of advocacy support and the contact details for the national advocacy services are included in the handbook. A multi-lingual poster about how to make a complaint includes contact details for the advocacy service. The resident's admission pack given on admission is left in the resident's room. Residents are feedback about their satisfaction is sought at six weeks post admission and at annual residents' meetings. .</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal privacy is maintained. All residents have their own room. Staff were observed to knock before entering a resident's room. It was observed on site and confirmed in interviews with residents and family/whanau that support for personal cares is conducted in a respectful manner. Individual values and beliefs are documented in care plans. Residents are supported to maintain their independence with the residents able to come and go within the building and grounds as they please. Residents are able to attend church or have their spiritual adviser attend them at the home. There are documented processes regarding abuse and neglect and all staff receive training. There were no reports of alleged abuse or neglect in the records sampled. The facility philosophy and values include respect for the dignity, privacy and independence of the residents and is displayed in the residents' lounge.</p> <p>Residents currently include European, Tongan, Sri Lankan, Argentinian, Maori and Fiji Indian ethnicities. Individual values and beliefs are discussed on admission and any special needs such as diet, spiritual practices, celebrations such as Diwali are identified.</p> <p>A spiritual/cultural/social and community needs assessment form and care plan is completed and used to inform the individual care plan. Families are encouraged to participate in meeting the cultural needs of the resident. Staff include Indian, Fiji Indian, Maori, European, Sri Lankan, Niue Islands, Philippines and can speak those languages.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability</p>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to residents who identify as Maori. Family/next of kin input and involvement in service delivery/decision making is sought if applicable. The staff interviewed reported that they understand and have attended cultural training and demonstrated the importance of whanau to residents who identify as Maori. The</p>

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. The Maori Health plan recognises the importance of whanau. A local Maori whiha ora kuia has an established relationship with the facility and provides support to residents who identify as Maori and to staff as required. A Maori staff member speaks some Maori and can also advise staff about cultural practices and beliefs. Cultural safety training for staff includes cultural competence, language barriers, body language and valuing our diverse culture. There were no residents who identify as Maori in residence at time of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The resident files sampled identified the cultural and/or spiritual needs of the resident in consultation with the resident and family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to provide guidance on delivery of individualised support in a culturally and/or spiritually sensitive manner. Staff interviewed reported on the need to respect individual culture and values. The residents reported that cultural and religious beliefs are respected and reported. There is access to church services if they wish to go. Individual birthdays and other events of individual importance are acknowledged and celebrated.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There is a documented policy and guidelines for staff that are in accord with the Human rights Act 1993. Definitions and examples are provided. The contact details for the Human Rights Commission are included. The staff code of conduct includes the right of residents to be free of discrimination, coercion, harassment, sexual, financial, or other exploitation. Interview with the facility manager (FM) and healthcare assistants (HCAs) indicates that staff understand the meaning of professional boundaries and how they are maintained.</p> <p>The employment position description and the Code of Rights define residents' rights relating to discrimination or exploitation. Staff interviewed verbalised they would report any inappropriate behaviour to the FM. The FM reported that formal action would be taken as part of the disciplinary procedure if there was an employee breach of conduct. Families interviewed confirmed that they felt their resident was safe and respected at all times.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The quality manager develops a planned yearly education programme that includes sessions that cover good practice topics. There is specialist advice available if required. There is regular in-service education and staff access external education that is focused on aged care and best practice. NZ Aged Care Association, conferences and seminars, NZ Quality Association website and other internet sources are used to inform annual policy and procedural reviews. Staff reported that they were satisfied</p>

		with the relevance of the education provided. Policies and procedures are linked to evidence-based practice, there are regular visits by the GP and links with the local District Health Board (DHA) Interventions sighted in care plans reflect evidence-based nursing practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their status, 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. There was also evidence of resident/family input into the care planning process. There is a policy to guide staff on the process around open disclosure. Accident/incident forms for the year to date were reviewed with evidence of open disclosure documented. Interviews with the operations manager and registered nurse (RN) confirmed family are notified following changes in health status. Family members interviewed stated they were kept informed of any health changes including accidents/incidents, infections and general practitioner (GP) visits. Three monthly family meetings provide a forum to discuss issues or concerns on every aspect of the service. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are able to be accessed via the DHB when and if required. Staff knew how to do so, although reported this was rarely required due to staff able to provide interpretation as and when needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ambridge Rose Villa (ARV) provides care for up to 31 residents requiring rest home care. Residential and respite care are available. The service holds contracts with the DHB for the provision of rest home care, respite services and care for young persons with a physical disability (YPD). On the day of audit there were 27 rest home residents, two of whom were under 65 years of age, and no respite residents. Resident records and interviews from both these service types were sampled. The Villa is one of three aged care facilities owned by the two directors. There is one governance body and CEO for the group. A Governance team of an Owner/CEO, Owner/Manager, Chief operating officer, Facilities manager (registered nurse (RN)), Head Chef (food services manager) and Quality Manager (activities leader) provide support across the group. Ambridge Rose Villa has its own facility manager who is supported by the Governance Team. Purpose, values, mission and goals are displayed in public areas in the facility. The group strategic business plan for 2018-2022 was last reviewed April 2018 and includes matters relating to aged care services. Specific planning and review processes for ARV are included in the ARV Business, Quality and Risk Management Plan and discussed every two months at governance / management meetings. Minutes sighted indicated all key matters are monitored against performance indicators and adjustments

		<p>are made as required. The documents describe annual and longer objectives and the associated operational plans. The Facility manager provides a monthly report to the chief operating officer who reports to the owner/CEO. A sample of reports reviewed show adequate information to monitor performance is reported including any emerging risks or issues.</p> <p>The CEO has 16 years ownership and management experience in the aged care industry. The service is managed by a registered nurse manager who has been at this rest home for eight years and in this role for two and a half years. The FM is a suitably skilled and experienced registered nurse and has responsibilities and accountabilities as defined in a job description and individual employment agreement. The FM and the chief operating officer interviewed confirmed a good understanding of the aged care sector, regulatory and reporting requirements. They maintain currency through attending training at the (DHB) and/or conferences or update days. The FM is supported by an experienced enrolled nurse. The FM maintains current interRAI assessment competencies.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The FM is responsible for day to day management of the services at ARV, human resources and staffing matters on site. Personnel training records confirmed that the FM has completed more than 8 hours training in management and aged care related topics in the past year. There is an enrolled nurse with four years' experience on site and another RN with 14 years' experience who can stand in for the FM if required. Both have received on-site leadership and management training from the FM and receive guidance from the group FM and the COO regarding the extent and limitations of their duties when deputising for the FM. There is a qualified diversional therapist for the group who is responsible for oversight of the activities programme.</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>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of incidents and accidents, complaints, audit activities, satisfaction surveys, monitoring of outcomes and clinical incidents including any infections. The group quality manager provides oversight and training to ARV.</p> <p>There is a quality and risk plan that addresses consumer focus, provision of effective programmes, certification and contract requirements, quality and risk management, continuous improvement. Goals, key performance indicators and responsible persons are defined. Progress towards achieving goals is reviewed at management meetings every two months. The quality and risk plan is shared with staff and issues discussed at staff meetings held every two months. Regular review and analysis of quality indicators occurs and related information is reported and discussed. Minutes sampled include discussion on pressure injuries, falls, complaints, incidents/events, infections and audit results and activities.</p>

		<p>Staff reported their involvement in quality and risk activities through the internal audits. There is a schedule of internal audits that is maintained by the quality manager (QM). The FM signs them off when any corrective actions have been completed and re-audited. Samples reviewed indicate that the schedule is implemented. Quality improvement reports are collated and displayed on the staff notice board every six months. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident/relative surveys are completed annually and indicate general satisfaction with services and care.</p> <p>Policies sampled cover all necessary aspects of the service and contractual requirements 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. Staff are updated on any new policies or changes to policies through the staff meetings. Hard copies of comprehensive policies and procedures are provided for staff at the nurses' station. The CEO, the quality manager and the group facility manager review the content of the documents at least annually and more often if systems change. An amendments page is maintained for each manual. Initial date and review dates are recorded. Staff may bring any suggestions for changes, improvements, corrections to the quality manager at any time. The CEO is responsible for ensuring that legislative changes are made in the manuals as required.</p> <p>The chief operating officer described the processes of identification, monitoring and reporting of any risks and development of mitigation strategies if needed. Any risks are discussed with the owner/CEO. The risk register is reviewed regularly. The chief operating manager is aware of the Health and Safety at Work Act (2015) requirements and has implemented the requirements.</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>	<p>FA</p>	<p>There is a documented policy and process for managing incidents, accidents and near misses. All such events or near misses are recorded on an incident form and reported through the FM to the COO. Resident related incidents are reported every two months to the management group in the clinical operations report. Staff related incidents are reported in the health and safety meeting and reviewed in the management meeting. A sample of incidents forms reviewed showed that they are fully documented. Incidents are investigated, action plans developed and actions followed up in a timely manner. Adverse events data is collated, analysed and reported to the owner/director and to staff at the staff meetings. Meeting minutes sampled show discussion has occurred regarding any trends identified, action plans and improvements made at the staff/quality meetings.</p> <p>Policy and procedures described notification reporting requirements. The nurse manager and chief operating officer are well informed on the responsibilities involved. There have been no notifications 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>	<p>FA</p>	<p>Documented policy defines the processes for recruitment and employment of staff. An employment lawyer is available for advice re employment matters. Policies and procedures are in line with good employer practice and relevant legislation. Job descriptions sampled were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of work visa, qualifications and practising certificates (APCs), where required. A sample of records reviewed confirmed the organisation`s policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from another staff member in the form of a `buddy` system through the initial orientation period. Staff records sampled show documentation of completed orientation and annual performance review.</p> <p>Continuing education is planned on an annual basis. Mandatory education requirements are defined and scheduled to occur annually via on line training programs. The FM and the registered nurse are fully trained interRAI assessors. Time is allocated for interRAI assessments to be completed. Education records reviewed demonstrated completion of the required training.</p> <p>All staff have current medication competencies. A physiotherapist reviews competence of manual handling. Competency is entered in the individual training record. The COO provides performance feedback to the FM.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. Staffing levels and skill mix comply with DHB contract requirements. There is a minimum of two staff on duty at all times with more on site during the day. Staff reported that there is good access to advice and extra help when needed. The FM is on call for clinical issues and the chief operating officer is contacted for non-clinical requirements as needed. Family/whanau/representatives interviewed felt that there is sufficient staff and their family member is safe. A sample of three rosters over the last 6 months confirmed adequate staff cover has been provided. No bureau staff are used. Rosters are fixed but staff can request a change. Staff phone list sighted. All care staff have a current first aid certificate.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>The group uses a computer program to record all admissions, transfers in and discharges/deaths. New information and updates are entered within 24 hours. The electronic register is automatically updated from the nurses` station computer. All residents have a hard copy file. All resident records are integrated</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>with allied health providers documenting their entries in a separate location in the integrated folder. Clinical records are documented daily, with additional entries as required from the registered nurse. All records are securely stored. Paper records are held in a locked office accessible to staff at any time. Old records are retained for 10 years and held in a secure archive store on site.</p> <p>Review of resident files confirmed that the records are legible, and the name and designation of the provider are identifiable. A copy of the current care plan signed by the family and the RN is kept in a locked cabinet at the nurses' station which is locked when unattended. Files are not taken off site. Electronic information is protected by individual password with automatic log-out if no activity in two minutes. The electronic data system is automatically backed up every few hours in a secure location off site. Guidelines for access to resident files are provided in the confidentiality agreement signed by all staff on employment. Legal access by others, such as police, health providers, is defined.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service is facilitated in a competent, equitable, timely and respectful manner. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Records sampled confirmed all entry requirements were conducted within the required time frames. 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>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification 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>	FA	<p>The documented medication management system complies with medicines legislation and guidelines. Residents receive medicines in a secure and timely manner. Medications are stored in a safe and secure way in the trolley and locked cupboards. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted, and all medications are stored appropriately. Medication reconciliation is conducted by the FM when the resident is transferred back to service. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated. Photos are attached to prescription records for easy identification and renewed every six months.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The FM was observed administering medicines following the required</p>

		medication protocol guidelines and legislative requirements. There are guidelines for managing safe self-administration of medicines by a resident if required. No resident was self-administering at time of audit.
<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>Meal services are prepared on site and served in the allocated dining rooms. The facility employs two chefs who are overseen by the executive chef from the same organisation. The menu has been reviewed by the registered dietitian. Diets are modified as required and the cooks confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. The family/whanau interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was registered under the food control plan. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers. Records of food temperature monitoring, fridges and freezers temperatures are maintained. The records are completed electronically through a food safety application. The application provides staff with up to date food safety training that is monitored by the executive chef. Kitchen staff completed training in food safety/hygiene. Regular cleaning is conducted.</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>	FA	<p>The FM reported that all consumers who are declined entry are recorded on the enquiry form. When a consumer is declined entry, family/whanau and the consumer are informed of the reason for this and made aware of other options or alternative services available in the community. The consumer is referred back to the referral agency to ensure that the consumer 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>	FA	<p>Initial assessment tools are used to assess the residents' needs, support requirements and preferences on admission. InterRAI assessments are completed in a timely manner. The assessed needs, outcomes and goals identified through the assessment process are documented to serve as a basis for service delivery. Assessments are conducted in a safe and appropriate setting. Assessment outcomes are communicated to the residents and/or their family/whanau and referrers and relevant service providers.</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>Care plans are resident focussed, integrated and provide continuity of service delivery. Long term and short- term care plans are developed for acute and long-term needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The documented interventions in short term care plans and long-term care plans were sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Clinical supplies are adequate, and the staff confirmed they have access to the supplies and products they needed.</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>	<p>FA</p>	<p>The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' files sampled reflect their preferred activities and are evaluated every six months or as when necessary. The activities coordinators develop a monthly activity planner which covers activities for the rest home and under those 65 years of age. Residents' activities information is completed in consultation with the family during the admission process.</p> <p>The residents were observed to be participating in a variety of activities on the audit days. There are planned activities and community connections that are suitable for the residents. There are regular outings for all residents (as appropriate). Family/whanau interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' long-term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Relatives and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when acute problems have resolved.</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>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Residents and family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GP.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies and procedures for the management of waste and hazardous substances are documented. All waste and hazardous substances (cleaning chemicals) are stored safely. Domestic and biohazardous waste is removed as per council requirements. Personal protective equipment is available. Staff receive education on the management of waste and hazardous substances and waste management audits are completed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility is sited in a 1930's villa and has been converted to a rest home. It has been well maintained and remains fit for purpose. Communal areas are adequate for the number of residents. Hand rails are installed throughout and there is level access to all areas. The furniture and fittings have been well maintained. Vinyl and carpet floor coverings are in good condition. Two wheelchairs and several walkers are provided. External areas are level and paved. There is open access to external areas and a pathway circumnavigates the home. Seating and shelter are provided in the garden. The gates to the facility are secured by coded access that is displayed by the gate.</p> <p>Staff report that there is sufficient medical equipment for resident care. Measuring equipment is calibrated annually. Electrical testing and tagging has been completed on all equipment and appliances. There is a maintenance schedule and a system for identifying any maintenance requirements as they occur. There is a hazard identification process and a risk, hazard and emergency response plan. Environmental audits are conducted. A current building warrant of fitness (expires 2/3/19) is displayed. There is a twelve-seater van for outings with current WOF, registration and pull-out steps for ease of access. There is a documented process regarding transportation for residents. There is a first aid kit in the van. All seats have seat belts.</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>	FA	<p>There are sufficient conveniently located single toilets and showers throughout the facility. All but one shower has recently been refurbished. There are reversible privacy locks on toilets and showers. Separate visitor and staff facilities are available. Each resident room has a hand basin and hand washing gel dispenser. Hot water temperatures in resident areas are monitored monthly and records indicate safe temperatures are maintained.</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>	FA	<p>All but one bedroom is single occupancy. The twin room is currently used as a single bedroom. Rooms are well maintained, are decorated with personal possessions and are of sufficient size to enable use of walkers or wheelchairs if required. All rooms have external windows and are exposed to natural sunlight.</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>	FA	<p>Communal areas consist of a large lounge, two smaller sitting areas, and two dining rooms. Communal areas are of a sufficient size to accommodate all residents. There is adequate room for activities. There are outdoor areas furnished with tables and chairs. All residents have access to the garden. The grounds are secured and safe for wandering residents.</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>	FA	<p>Designated household staff do the cleaning and laundry. Cleaning and laundry duties are documented. Personal protective equipment and clothing is provided. The staff confirmed that cleaning and laundry equipment is sufficient to meet the needs of residents. They are designated secure areas for laundry and cleaning appliances and activities. Laundry chemicals are dispensed from fixed containers. Cleaning chemicals are labelled and material data safety sheets were sighted. All laundry is washed on site. The laundry is separated into clean and dirty areas. The large domestic washer and dryer are in good working order. Laundry can be dried outside. Cleaning and laundry staff have received education regarding the use of chemicals which is conducted by the chemical provider. Laundry and cleaning caregivers were able to describe infection control practices. Cleaning and laundry services are</p>

		monitored through resident satisfaction surveys and internal audits with good results.
<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>	FA	<p>There is an approved fire evacuation plan 16/04/99. There have been no changes to the building or services since then. Trial evacuations are conducted every six months. There are fire extinguishers throughout the building. Regular inspections to support the building warrant of fitness are documented.</p> <p>There is an emergency and disaster response plan which covers a range of emergencies. There is sufficient equipment, extra blankets, food and clinical supplies and water for at least three days stored on site in the event of an emergency or if the mains supply fails. There is a small potable petrol generator that will supply power for 2 hours on one tank. There is emergency lighting on battery for four hours, electric head torches and extra batteries. The kitchen hobs are run on gas. There is also a gas barbecue for cooking. There are first aid supplies and all staff have completed first aid training. There are sufficient continence pads and toilet paper for one week. Additional infection control supplies for a pandemic are stored on site.</p> <p>All resident bed spaces and communal areas have call bells, including toilets and showers. The level of support each resident would need in the event of an emergency is documented in their care plan. Alternative accommodation is available at the two other facilities under the same owner should the building have to be evacuated.</p> <p>The home is on one level. There are several clearly marked exits from the building. All exits allow free egress but require keys or codes to enter from the outside. External doors and windows are checked each evening and monthly security check lists are completed to ensure the facility remains safe and secure at all times. Families interviewed confirmed that they felt their resident was safe and secure.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Every resident bedroom and all communal areas have natural light and ventilation. Heating is provided through wall radiators in every room. There are no residents who smoke. The designated external area for staff to smoke is well away from resident areas.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment,</p>	FA	<p>The service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The role of the infection control coordinator (ICC) is held by the FM who has access to external specialist advice from the GP</p>

<p>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>practice and DHB infection control specialists when required.</p> <p>The infection control programme is approved and reviewed annually. Infection rates are discussed at monthly staff and health and safety meetings. Staff are made aware of new infections through daily handovers on each shift and reporting.</p> <p>There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</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 ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Collation, analysis and reporting of infection are completed and discussed at three monthly staff and management meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</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 service has documented policies and procedures in place that reflect current good practice. Staff were observed to be following the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by ICC and other specialist consultants. The ICC attended the infection control training facilitated by the local DHB to keep knowledge of current practice. A record of attendance is maintained and was sighted. The infection control training content</p>

<p>relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>meets best practice and guidelines. External contact resources included: GP practice, laboratories and local district health boards. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>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.</p>	<p>FA</p>	<p>Surveillance of infections is carried out as specified in the infection control programme. The ICC reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. All infections are recorded on the infection register, this information is collated monthly, reviewed and analysed by the ICC who will advise staff and management of the outcome.</p> <p>The GP is notified if there is any resistance to antimicrobial agents and evidence of GP involvement and laboratory reporting was sighted. Surveillance programme is reviewed during the infection control programme review.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Ambridge Rose Villa actively works to minimise the use of restraint. The policy provides consistent definitions for restraints and enablers. There were no residents using restraint or enablers. There is a secure gate with key code displayed at the front of the property. Family/whanau and residents are able to go out and come back as they please. Staff receive ongoing education on the use of restraint and challenging behaviours. In interview conducted, staff demonstrated awareness on the difference between a restraint and an enabler.</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.

No data to display

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.