

Ellora Enterprises Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Ellora Enterprises Limited

Premises audited: Sheaffs Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 22 January 2015 End date: 23 January 2015

Proposed changes to current services (if any): Three smaller resident rooms have been converted to two medium size bedrooms with a share toilet. This reduces the bed numbers from 30 to 29 (as of March 2014). HealthCERT had not been notified. The bedrooms were sighted on the day of audit and meet the standards for rest home level of care.

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

Sheaffs rest home provides residential care for up to 29 residents. Occupancy on the day of the audit was 27 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The facility is owner/operated by current manager for 23 years. The service has sufficient staff allocated to enable the safe and timely delivery of care. Residents and family were complimentary on the standard of service and care provided.

The two previous shortfalls from the certification audit around appraisals and medical reviews have been addressed. This audit identified an improvement around documentation of interventions.

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.
--	--	--

There is an open disclosure policy. Interviews with residents and relatives confirm family are kept informed of their family member's current health status including any adverse events. A complaints register is in place. The one complaint had been managed appropriately.

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.
---	--	--

The service continues to implement a quality and risk management framework that includes management of incidents, complaints and infection control surveillance data. There is an implemented internal audit programme to monitor outcomes. The owner/operator/manager is supported by a part-time registered nurse and an enrolled nurse.

There are human resources policies including recruitment, selection, orientation and staff training and development. The previous finding regarding staff appraisals has been addressed. There are adequate staff numbers on duty.

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 medium or high risk and/or unattained and of low risk.
--	--	--

Assessments, care plans and evaluations are completed by the registered nurse. Care plans reviewed were individualised and risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and have been evaluated six monthly. The resident and family confirm they were involved in the care planning process and were complimentary about the staff and standard of care provided. The general practitioner completes three monthly reviews. This is an improvement since the previous audit.

The diversional therapist provides a five day activities programme for the residents that is varied, interesting and involves community visitors and outings.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. The GP reviews the medication chart three monthly.

The service prepare and cooks all meals on site and the menu has been approved by a dietitian. Individual dietary needs, likes and dislikes are catered for. Residents interviewed responded favourably to the food that was 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.
--	--	--

Sheaffs rest home holds a current warrant of fitness. Upgrading and refurbishment of bedrooms is on-going. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a planned maintenance schedule. The outdoor areas are safe and easily accessible with seating and shade.

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.

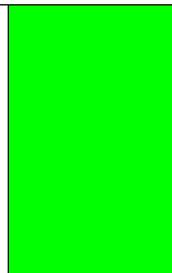


Standards applicable to this service fully attained.

The restraint policy and procedure has a clear definition of restraint and enablers. Restraint is used as the last resort. There are no residents requiring restraint or enablers.

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.

There is an established and implemented infection control programme that is linked to the quality system including monthly reporting and monitoring of surveillance data. This includes audits of the facility and surveillance of infection control events and infections. The infection control programme has been reviewed. Infection control education is provided at least annually and on-going.

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	0	1	0	0
Criteria	0	41	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy guides practice. The RN is the privacy officer and responsible for the investigation and management of complaints (verbal and written). There is a complaints register in place. There has been one complaint since the previous audit. The complaint has been managed in line with Health and Disability Commissioner Code of Rights. Three caregivers (interviewed) were knowledgeable around the complaints process and resident advocacy and rights.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry. The relatives and residents (interviewed) confirmed they are aware of the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is a policy to guide staff on the process around open disclosure and accessing interpreter services. Family complete a notification of accident/incident form on admission. There was documented evidence of family notification as requested. Relatives interviewed (two) confirm they are kept up to date with the resident's health status. The manager operates an open door policy. Residents interviewed (six) stated the manager is very approachable and makes contact with them daily. Families receive regular newsletters.</p> <p>D12.1 Non-Subsidised residents were advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" was provided to residents on entry.</p>

<p>conducive to effective communication.</p>		<p>D16.1b.ii The residents and family were informed prior to entry of the scope of services and any items they have to pay that was not covered by the agreement. D16.4b Two relatives (interviewed) stated that they are informed when their family members health status changes. D11.3 The information pack was available in large print and this can be read to residents. There was an interpreter service available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Sheaffs rest home provides care for up to 29 rest home level residents. On the day of audit there were 27 rest home residents. This included one respite care resident admitted on the day of audit.</p> <p>Sheaffs rest home is operated by an experienced non-clinical owner/manager for over 23 years. She is supported by a part-time experienced registered nurse and an enrolled nurse Monday to Friday. The manager and RN share the on-call.</p> <p>The business plan for 2014 has been reviewed and a 2015 business plan and goals have been developed for 2014. The goals are regularly reviewed and entered into a data base recently developed by the manager. Goals for 2015 include ongoing refurbishment and upgrading of the facility.</p> <p>ARC, D17.3di The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. The manager has attended manager workshops and study days, providers meetings, education on abuse, neglect and code of rights.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Sheaffs rest home has continued to implement a quality and risk management system. There are policies and procedures being 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. Policies are reviewed on a regular basis.</p> <p>There are two monthly staff/quality meetings that covers quality, health and safety and infection control. Monthly data is documented in the meeting minutes (sighted). Three caregivers (interviewed) confirm quality data, trends and corrective actions are discussed at staff meetings. Resident meetings are held monthly and minutes demonstrate discussion around all services and issues raised have been followed up. Residents interviewed confirm they attend the resident meetings and provide feedback on the service.</p> <p>The service has an annual internal audit schedule. Internal audits cover each area of service delivery. Outcomes and corrective actions (as applicable) are discussed at the quality/staff meetings.</p> <p>Internal resident/relative surveys were completed September 2013 with all results satisfied/very satisfied. A six week post admission survey is completed for each resident with any concerns followed-up by the manager. Annual activities surveys had been completed with positive feedback.</p>

		<p>D19.3: There is a health and safety (H&S) and risk management programme in place including policies to guide practice and hazard reporting forms (sighted). The manager has overall responsibility for Health and safety. The service has an H&S representative.</p> <p>D19.2g Fall prevention policies and strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. A physiotherapist is available by referral.</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>D19.3c: The service collects incident and accident data and reports to the quality, health and safety and infection control meeting. Incident forms are completed by staff and the on-call is notified (link 1.3.6.1). Ten incident forms reviewed for December 2014 were signed off by the registered nurse or manager and had been documented in the resident progress notes. The caregivers interviewed could discuss the incident /accident reporting process.</p> <p>D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements can be made. Discussions with service management, confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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 RN and enrolled nurse (EN) practising certificates were current. Six staff files were reviewed and all had relevant documentation relating to employment. Annual performance appraisals were completed in the files reviewed. This is an improvement since the previous audit.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The RN has proficient level of the district health board professional development recognition programme relevant to her part-time DHB employment. She has been employed with Sheaffs rest home since 2008, has a current first aid certificate and has completed InterRAI training and other relevant education.</p> <p>There is a two yearly education plan in place that includes all required education as part of these standards. Existing caregivers hold the national certificate in the support of the older person. Newly appointed staff are supported to commence aged care qualifications. In addition to on-site education, staff are encouraged to complete</p>

		on-line learning and have access to the office computer.
<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>The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager was on-site Monday to Friday. Works a minimum of 10 hours per week and is flexible and available to complete assessment admissions and attend residents of concern. The manager and RN share the on-call. There is an EN on duty Monday to Friday. There are adequate numbers of caregivers on duty each shift.</p> <p>Staff interviewed state 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>All medication is managed appropriately in line with required guidelines and legislation.</p> <p>There are policies and processes that describe medication management that align with accepted guidelines. The RN, EN and care staff administer medications. Staff complete medication competencies and education annually (including on-line education). The local hospice provide support for residents who require end of life medication. Two self-medicating residents have self-medication assessments that were reviewed three monthly. Medications requiring refrigeration was stored in the kitchen fridge in a sealed container. All medications in the medication trolley were within expiry dates. Standing orders were not in use. Medication reconciliation forms were evidenced in use.</p> <p>Ten medication charts sampled identified all medication charts had photo identification and allergies/adverse reactions noted. Medications charts are pharmacy generated and prescribing meets the legislative requirements.</p> <p>D16.5.e.i.2; Ten out of 10 medication charts reviewed identified that the GP had reviewed the medication chart three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs</p>	FA	<p>There are food policies/procedures for food services and a three weekly rotation menu that has been reviewed by a dietitian. The menu is currently under review. The cook on duty prepares and serves all meals. The cook receives a resident diet profile (including dislikes and food allergies) on admission. Alternatives are offered for dislikes. Residents interviewed confirmed they are offered alternative choices. Snacks are available at any time as required. There were normal, diabetic and one mouli diet being provided. Reviews and changes in dietary requirements were communicated to the cook.</p> <p>Fridge, freezer and end cooked temperatures were checked and recorded. Dry goods in the pantry are sealed,</p>

<p>are met where this service is a component of service delivery.</p>		<p>dated, labelled and off the floor. Perishable foods were date labelled. There are cleaning schedules in place. Chemicals are stored safely.</p> <p>Residents have the opportunity to provide feedback and suggestions on the menu through resident meetings and surveys.</p> <p>D19.2; the cooks have completed food safety and hygiene training.</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>PA Moderate</p>	<p>When a resident's condition alters, the RN or EN initiates a review and if required GP. Relative notification is documented in the resident's progress notes. Family interviewed confirmed they are notified when the resident's health status changed. Resident care plans overall were individualised to support the resident goals. Short term care plans were in place for short term/acute needs. Residents interviewed state their needs are being met. Shortfalls are identified around assessments and aspects of care planning.</p> <p>D18.3 and 4; There were adequate dressing supplies and continence products available. There was one chronic ulcer being actively managed. Wound assessments and evaluations were completed. The RN described the referral process for the wound nurse or district nurse.</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 service employs a qualified diversional therapist (DT) Monday to Friday for 35 hours a week, who has been in the role 14 years. She attends all on-site education and has a current first aid certificate. The DT attends two monthly regional DT meetings. There is an activity programme that includes exercises, newspaper reading, bowls, walks, arts and crafts, entertainers, speakers, inter-home visits and outings. The residents are involved in community events and fundraisers. Recently the knitting group entered a community competition winning awards for their knitting which were then donated to charity. There is a visiting chaplain and kaumatua/kuia. Residents spiritual and cultural needs were being met as evidenced in resident interviews.</p> <p>A resident social history is completed on admission. D16.5d. The individual activity plan is part of the long term care plan and reviewed six monthly as part of the multidisciplinary team review. Resident meetings are held six monthly which includes discussion on activities. Residents interviewed enjoy the activities offered, outings and entertainment provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>The RN involves the manager, EN, DT, caregivers and resident/family in the review of the care plan. Goals are identified as met or unmet. There is a three monthly review by the GP. Families are invited to the three monthly reviews. Short term care plans sighted had been evaluated with ongoing problems documented in the long term care plan.</p>

evaluated in a comprehensive and timely manner.		D16.4a; Care plans are evaluated six monthly more frequently when clinically indicated. ARC: D16.3c; All initial care plans reviewed were evaluated by the RN within three weeks of admission.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The facility holds a current warrant of fitness which expires 7 June 2015. The owner/operator (husband) oversees the maintenance and repairs for the facility. There is on-going refurbishment and upgrading of the facility including bedrooms. Three smaller rooms were converted into two medium size rooms with a shared toilet in March 2014 which reduced the bed numbers to 29. HealthCERT had not been notified at that time. The bedrooms sighted meet the standards for rest home level.</p> <p>Electrical equipment has been tested and tagged annually. Clinical equipment had been calibrated and serviced July 2015. The corridors were sufficiently wide enough to allow residents to mobilise with the aid of walking frames. There is safe access to the outdoor areas and gardens with seating and shaded areas. There is a designated external resident smoking area.</p> <p>ARC D15.3; There was adequate equipment available for rest home level of care. The caregivers and RN interviewed state they have all the equipment referred to in long and short term care plans necessary to provide care such as pressure relieving equipment, shower stools, transfer belts, wheelchairs, walking frames, mobility aids, electric beds, chair scales and a hoist.</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.	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data was collected, collated and analysed monthly to identify trends, areas for improvement or corrective action requirements. Data, trends, corrective actions and quality improvements were discussed at staff/quality meetings. Meeting minutes were sighted.</p> <p>Infection control responsibilities are shared between the RN and EN. The 2014 infection control programme which includes surveillance was reviewed. Education on infection control is included in orientation and annually.</p> <p>There have been no outbreaks since the previous audit.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The restraint minimisation and safe practice policy identifies that restraint is used as a last resort. The service currently has no residents on restraint or enablers.

that the use of restraint is actively minimised.		
--	--	--

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>	<p>PA</p> <p>Moderate</p>	<p>Risk assessments tools are available for use such as continence, falls, pressure area, nutritional, pain, mobility and wound assessments. Resident weight is recorded on admission and monitored monthly.</p>	<p>(i) There was no pain assessments in place for three residents with identified pain. (ii) There was no neurological observations or clinical assessments completed for one resident who had two falls with head injury. 3) There was no documented interventions for a) resident with vomiting and nausea, and b) resident with weight loss.</p>	<p>(i)Ensure appropriate assessments are completed; (ii) Ensure interventions are documented to reflect the resident's current health status.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.