

Elsdon Enterprises Limited - Ashlea Grove

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:	Elsdon Enterprises Limited
Premises audited:	Ashlea Grove Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 February 2015 End date: 17 February 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	20

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ashlea Grove rest home is privately owned and employs a nurse manager who has been in the role since February 2014. The nurse manager is supported by an enrolled nurse and care staff. The service provides rest home and dementia specific level care for up to 37 residents, with 20 residents accommodated on the day of audit. Family and residents interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed 20 of the 31 previous certification audit findings relating to: communication with family, informed consent, completing internal audits as per the schedule, recording on-going hazards, notifying authorities of residents change of level of care, completion of orientation for new staff, provision of appropriate staff cover, completion of medication competencies, residents nutritional needs are met, food safety practices, safe chemical storage, calibration of medical equipment, maintaining an odour free environment, provision of supplies of emergencies, review of restraint policies, approval, assessments and planning for environmental restraint, maintaining best practice for infection prevention and control measures and infection surveillance documentation.

Further improvements continue to be required around; maintaining residents privacy, reviewing and updating all policies, linking components of service delivery to the quality system, reporting and management of adverse events, ensuring staff appraisals are

completed annually, delivery of the planned education programme, timeframes for completion of assessments and care planning, completion of resident risk assessments, aspects of care planning, aspects of medication documentation and administration, and repair of bathroom floor covering.

This surveillance audit also identified improvements required around analysis of quality data, development of corrective actions following quality activities, and evidencing registered nurse input in to aspects of care planning.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Previous audit finding relating to maintaining visual privacy for residents continues to require improvement. Communication with residents and families is appropriately managed. The service has met the previous finding relating to communication with family following incidents and accidents. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Ashlea Grove rest home has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The service is privately owned and is managed by a nurse manager with considerable experience in aged care. The facility is guided by a set of policies and procedures which have been reviewed in part. Further improvements are required in this area. Quality activities are conducted. The service has addressed previous findings relating to completion of internal audits, completion of satisfaction surveys, hazard reporting, business and quality plan completion, clinical service availability, job descriptions, orientation, and conducting reference checks. Improvements continue to be required in relation to reporting and management of adverse events, conducting meetings, staff appraisals and providing mandatory education. Further improvement is required in relation to analysis of quality data and developed of corrective actions. Staffing levels are appropriate and a four week roster is in place.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents and family members interviewed state that they are kept involved and informed about the resident's care. Assessments and care plans are developed by the enrolled nurse and nurse manager. Improvements are required whereby the nurse manager signs off on all aspects of care planning. Improvements continue to be required whereby all residents have a plan of care in place and all aspects of assessments and care plans are completed within the required timeframes. Care plans are individually developed with the resident, and family/whanau involvement is included where appropriate. Long term care plans have been evaluated six monthly or more frequently when clinically indicated and the service has addressed this previous finding. A range of activities are available in both rest home and dementia units and rest home residents provide feedback on the programme. The medication management system includes policy and procedures that continues to require review. Staff responsible for medication administration receive training and competencies have been conducted. Medication storage and security has been enhanced. The service has made improvements in these areas. Resident medications are reviewed by the residents' general practitioner at least three monthly. Improvements continue to be required around medication administration documentation, and administration practices. Ashlea Grove has food policies and procedures for food services and menu planning appropriate for this type of service. Nutritional and safe food management in-service is completed by staff. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. The service has addressed and monitored previous findings relating to meeting resident nutritional needs, and aspects of safe food practices.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Ashlea Grove has a current building warrant of fitness certificate that expires on 12 July 2015. The service has addressed and monitored previous findings in relation to securing of chemicals in the dementia unit, calibration of medical equipment, eliminating environmental odours, and provision of a gas bottle for the BBQ. Further improvements continue to be required in relation to ensuring all hazards including uneven floor surfaces, are managed appropriately.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has addressed a previous finding in relation to review of environmental restraint policy. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there was one resident assessed as requiring environmental restraint (as per resident choice) and no enablers. Restraint is only used as a last resort and is managed appropriately including assessment, consent, care planning and monitoring. Staff are required to attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually. Improvements have been made in relation to environmental restraint for rest home residents.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Improvements have been made in relation to previous findings relating to infection surveillance and infection prevention practices.

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	18	0	0	9	0	0
Criteria	0	38	0	3	10	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Previous certification audit identified that informed consent forms were not evident in all resident files reviewed. On review of seven resident files (three rest home and four dementia) all files evidenced that informed consent has been obtained and this is documented. The service has addressed this previous finding.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	The service has a complaints policy and procedures in place and residents and their family/whānau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with all documentation which shows that complaints are managed and resolved. Residents and family members advised that they are aware of the complaints procedure and how to access forms.

understood, respected, and upheld.		
<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>	PA Moderate	<p>Previous certification audit identified that a communal toilet area in the dementia unit and one toilet facility in the rest home did not meet privacy requirements for residents. The service has taken steps to address this issue with all rest home toilet facilities now having a vacant or in use sign attached. The closure of one set of doors with curtains over the glass panels, in the dementia unit, has been provided to maintain visual privacy in the bathroom area. However, the dementia unit area has another door way which remains an open space leading to the bathroom.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Five rest home residents and two dementia family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings take place (link #1.2.3.5) and the nurse manager has an open-door policy. The previous finding relating to communicating with family following resident incidents and accidents has been addressed and monitored. The service has instigated a family contact sheet in resident files and staff confirm that they contact family following incidents. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English then the interpreter services are made 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</p>	FA	<p>Ashlea Grove Rest Home provides rest home level care for up to 37 residents in a 15 bed dementia unit and a 22 bed rest home wing. Occupancy on the day of the audit included 10 residents in the dementia unit including one respite, and 10 rest home residents. The mission statement sets out the vision and values of the service and is included in the information booklet, which is given to each resident and family on admission.</p> <p>An organisational chart visually describes reporting relationships for the management structure. The service has a business and quality plan for 2014 - 2016 which has been introduced by the owners. The internal audit programme assesses service performance (# link 1.2.3.6). The nurse manager is in contact with the owners via e-mail and phone contact. The nurse manager has been at the service since October 2012 (employed as a registered nurse) and has been in the role of the nurse manager since Feb 2014. She is supported by an enrolled nurse with</p>

consumers.		experience in aged care. The nurse manager has maintained at least eight hours of professional development.
<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>	PA Moderate	<p>The organisational manual includes the quality assurance and risk management programme. The business and quality plan for 2014 – 2016 has been signed off by the owners and is being implemented. The service has addressed this previous finding. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored by the nurse manager, enrolled nurse and discussed at the general staff meeting. An annual review has been completed for all areas of service. Staff meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Discussions with nurse manager, enrolled nurse and three caregivers confirm their involvement in the quality programme. Previous certification audit identified that not all meetings had been held as per meeting planner. Staff meetings have been held two monthly since previous audit. Only one resident meeting has been held (planned for three monthly) and no management meetings have been held. Restraint and enabler use is reported within the general staff meetings.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. It is noted that the analysis of monthly incident and accident data has not been collated for December 2014 and January 2015. There is an internal audit schedule which is being implemented. The service has made improvements in this area. Areas of non-compliance identified at internal audits are identified; however, corrective actions have not been developed for all areas requiring improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The hazard register has been reviewed in December 2014. This previous finding has not been addressed. Policies and procedures are in place for all aspects of the service and there is evidence of review. Some improvement have been made in relation to this previous finding, however, one aspect of the medication policy continues to require review. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The service has addressed the previous finding in relation to collation and analysis of the last resident/family survey.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p>	PA Moderate	<p>Incident and accident data is collected and analysed. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for December 2014 and January 2015 were reviewed. All reports and corresponding resident files reviewed evidence that clinical care is provided following an incident with review of the resident conducted by either the enrolled nurse or the nurse manager. It is noted, however, further care is required for</p>

<p>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>residents who have had unwitnessed falls and possible head injury. Reports were completed and family notified as appropriate. The nurse manager advised that she reviews all incident reports, however, this is not recorded on the reports reviewed. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Improvement is also required whereby all pressure injuries are reported. Previous certification audit identified that not all residents were receiving care and support appropriate to their assessed needs. The service has addressed this previous finding.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates are kept. There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed and included all appropriate documentation with the exception of two staff appraisals. Previous certification findings have been addressed in relation to staff position descriptions and reference checks for new staff. Staff turnover was reported as low. The service has an orientation programme that provides new staff with relevant information for safe work practice. The previous finding has been addressed and monitored. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The education calendar for 2014 was completed in part. Care workers have completed either the national certificate in care of the elderly or have completed or commenced an aged care education programme. Caregivers who work in the dementia unit have either completed or are working towards completion of the required unit standards. The service has addressed this previous finding. An education assessor is employed to oversee the completion of these unit standards. The nurse manager and enrolled nurse attend external training including conferences, seminars and education sessions with the local DHB. Fire drills have been conducted six monthly. The service has addressed this previous certification finding.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	<p>FA</p>	<p>Ashlea Grove has a four weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one care giver on duty in the dementia unit and one care giver on duty in the rest home area at all times. The full time manager is a registered nurse. An enrolled nurse is also employed as clinical support and shares the on-call with the nurse manager. The local GP also provides after hours care if required and caregivers have access to the local ambulance service. Caregivers advised that sufficient staff are rostered on for each shift. Staff turnover is low. Both registered nurses and caregivers are trained in first aid. Previous certification findings relating to access to registered nurse after hours and provision of consistent care staff in the dementia unit has now been addressed.</p>

and/or experienced service providers.		
<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>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements with the exception of resident's self-medication policy (link # 1.2.3.3). Aspects of the previous certification audit findings have been met in relation to medication orders, standing orders, transcribing, medication storage and staff competencies. All clinical staff who administer medications have been assessed for competency. Education around safe medication administration has been provided. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration, however, one observation during the audit did not support this. A contracted pharmacy supplies packed medications. Medications are managed appropriately in line with required guidelines and legislation with the exception of the controlled drug register. Medication charts evidence that the GP had reviewed medications three monthly and sampled met all the prescribing requirements with one exception. Each drug chart has a photo identification of the resident. Allergies or nil known allergies were recorded on the medication chart. There were no residents who self-medicate. Internal medication audits are conducted six monthly. Medication charts reviewed identified that the GP had seen and reviewed the resident 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 are met where this service is a component of service delivery.</p>	FA	<p>There is a small functional kitchen at Ashlea Grove and all food is cooked on site. The service provides meals on wheels to the community and the local district council has signed off an annual registered commercial kitchen audit. There is a four weekly menu with dietitian review and audit of menus. Cooks and kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses. A dietitian is available via referral to review residents. Nutritional assessments have not been conducted for all residents with identified issues (link #1.3.4.2) however, one resident is receiving ensure supplement drinks for identified weight loss and low appetite. Weights are monitored monthly or more frequently if required and as directed by the dietitian or GP. Residents provide feedback on the meals and food services. Interviews with residents and family members indicate satisfaction with the food service. Previous certification audit findings relating to meeting nutritional needs of residents, and aspects of safe food management have been addressed and monitored.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and</p>	PA Moderate	<p>Previous certification audit identified that not all assessment had been completed for all identified care issues. On review of seven resident files an initial nursing assessment was completed within 24 hours of admission for seven of seven resident files reviewed. The service has made improvements to this aspect of the finding. Further risk assessments have been completed for four residents. Three residents have not had risk assessments conducted for identified care issues. There are risk assessment tools available for use including continence, nutrition, pain,</p>

preferences are gathered and recorded in a timely manner.		falls, pressure risk and behaviours. The nurse manager advised that she has commenced the use of the interRAI assessment tool, however, no files reviewed included this tool. Assessments conducted are done so in an appropriate and private manner.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Previous certification audit identified that not all residents had an initial care plan developed, not all permanent residents had a long term care plan in place and short term care plans were not well utilised for all needs. The service has addressed aspects of the previous finding relating to use of short term care plans where required. Activities assessments and plans were reviewed in the sample of resident files. Four of seven residents have an activities plan in place. One of seven is not yet due for completion, and two permanent resident files do not evidence an activities plan.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Ashlea Grove rest home provides care to rest home and dementia level residents. Individualised long term care plans have been developed for four of seven permanent resident files reviewed (link #1.3.5.2). A written record of each resident's progress is documented. Changes are followed up a registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and a treatment rooms is well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans and evaluations and progress notes for all wounds. Advised that wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short term care plans with interventions and on-going evaluations by the RN were evidenced. A physiotherapist referral is initiated if required and assessment of any equipment needed.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture,	FA	The activities coordinator at Ashlea Grove provides an activities programme over five days per week for three hours a day. The diversional therapist (DT) allocates one hour for rest home residents and two hours for dementia residents and has one extra hour per week for administration. There is a monthly activity planner. A range of activities are available and these include the involvement of the residents into the community. The programme reflects resident's interest in the environment and they have choice in their level of participation. Ashlea Grove has a van which is used for resident outings at least once a week. One-to-one support is provided in situations where residents are unable to participate in group activities. Care staff assist in providing diversional therapy and activities in the dementia unit when the DT is not on duty and have access to resources. Rest home and dementia residents are provided with a mixture of combined activities and a separate programme. A resident social profile is completed on admission. Attendance records are maintained for each individual.

and the setting of the service.		Residents interviewed spoke positively of the programme. Activities are discussed with residents to ensure that the activity programme is appropriate for the residents who currently reside at Ashlea Grove. The diversional therapist stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions. Resident files reviewed identified that an individual activity plan is developed and reviewed (with exceptions link #1.3.5.2.).
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial care plans were evaluated within three weeks of admission. Long term care plans have been reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur as sighted in the files reviewed. A multi-disciplinary team meeting is conducted six monthly for each resident and involves all relevant personnel. The GPs examine the residents and review the medications three monthly. Short term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long term care plan as an on-going problem.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Previous certification audit identified that cleaning chemicals were not stored securely in the dementia unit. Advised that the enrolled nurse has been conducting checks to ensure that this practice has been eliminated. During a tour of the facility and during the audit, no chemicals were observed in communal bathroom areas and were stored securely in the locked cleaner's storage cupboard. The service has addressed and monitored this previous finding.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical	PA Moderate	The service displays a current building warrant of fitness which expires on 12 July 2015. One aspect of the previous audit finding relating to calibration of medical equipment has been addressed. Improvements continue to be required in relation to one bathroom with uneven floor covering.

environment and facilities that are fit for their purpose.		
<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	Previous audit finding relating to maintaining cleanliness and odour free environment has been addressed.
<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	Previous audit finding relating to the provision of a gas bottle for the service's bbq has been addressed.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	FA	Previous certification audit identified that infection control practices required improvement. During a tour of the facility it was noted that disposable hand towels were provided and towels were not stored in communal bathrooms. The service has addressed this previous finding.

appropriate to the size and scope of the service.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection prevention and control policy. The nurse manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. The service has made improvements in this area. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. The service has addressed this previous finding. Surveillance of all infections are entered on to a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has addressed a previous finding in relation to review of environmental restraint policy. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit there was one resident assessed as requiring environmental restraint (as per resident choice) and no enablers. Restraint is only used as a last resort and is managed appropriately including assessment, consent, care planning and monitoring. Staff are required to attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed annually. Improvements have been made in relation to environmental restraint for rest home residents.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration</p>	FA	<p>Previous audit identified that appropriate approval for restraint is obtained and documented. The service has addressed this previous finding. Restraint approval documentation was reviewed and has been completed.</p>

of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Previous certification audit identified that a resident had not been assessed for environmental restraint. Appropriate assessment documentation has been completed as evidenced in a resident file reviewed. The service has addressed and monitored this previous finding.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Previous certification audit identified that the resident with environmental restraint did not have this recorded in the long term care plan as part of the care planning process. This finding has been addressed as evidenced in the file reviewed.

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 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	<p>PA</p> <p>Moderate</p>	<p>All rest home bathrooms have privacy locks and in use/vacant signs attached. The dementia unit has a two toilet communal bathroom situated in close proximity to the hallway and resident communal lounge and dining area. The bathroom has two doorways leading to the bathroom. One door way directly off the hall way has been closed with net curtains over the glass panels, to ensure privacy is maintained. However, the other door way has no door attached, and this leads directly in to the bathroom area. One toilet in this area has a door, one toilet still has a curtain attached.</p>	<p>One toilet in the dementia unit communal bathroom has a curtain in place of a door and an open entrance door way leading to the communal bathroom facility.</p>	<p>Ensure that resident’s privacy is maintained in all communal toilet and bathroom facilities.</p> <p>60 days</p>
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that</p>	<p>PA</p> <p>Low</p>	<p>Policies and procedures are in place covering all aspects of care and service delivery. Review of the policies is conducted by the nurse manager with input from staff. The service has partially addressed a previous finding relating to two yearly review of policies including a review of skin care. Skin care and management is included in continence and pressure injury</p>	<p>The policy on resident self-medication has not been updated to reflect the current medication guidelines. There is no reference in the policy to</p>	<p>Conduct a review of the resident self-medication policy to include resident three monthly competency reviews.</p>

are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.		prevention policies. The resident self-medicating policy has been reviewed but not updated to reflect the current medication guidelines.	three monthly reviews including resident competency.	90 days
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	The meeting schedule for 2014 included management, staff and resident meetings. Staff meetings have been held one to two monthly. One resident meeting was held in September 2014. The management meeting has not been conducted. Advised that quality data is reported to staff via the staff meeting and this was evidenced in staff meeting minutes reviewed.	Resident and management meetings have not been held as per meeting planner.	Ensure that meetings are held as scheduled 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Quality improvement activities as the quality plan, include the annual resident and family survey, gathering of incidents and accidents data, internal audits, meetings, complaints and resident feedback and these provide for the collection of information. The resident survey was conducted in February 2013 and the collation and analysis of the results has been conducted by the nurse manager with feedback provided to staff and residents. The service has addressed this previous finding. Internal audits are conducted as per the internal audit schedule. Incidents and accidents data has been collected monthly and advised that the nurse manager collates this information. Analysis was noted not to have been conducted for December 2014 and January 2015 collection of incident reports.	Collation and analysis of incidents and accident reports for December 2014 and January 2015 has not been conducted.	Ensure that collation and analysis of incident and accident data is conducted in a timely manner. 60 days
Criterion 1.2.3.8	PA	Internal audits have been conducted as per the audit schedule as	Corrective actions have not	Ensure that

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	Moderate	evidenced in the documentation reviewed. On review of the audits conducted it is noted that corrective actions have not been fully developed, completed and signed off for all audits.	been developed and completed following internal audits and where short falls in service have been identified. These included environmental (July 2014), admission audit (December 2014), and care planning (January 2015).	corrective actions are developed and followed through for all areas of non-compliance identified through quality activities. 60 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	The service gathers incident and accident data for resident and staff incidents. Resident incident forms were reviewed for December 2014 and January 2015. Incident data includes falls, skin tears, bruising, medication errors, behaviours, near misses, and serious harm. The sample of incident reports reviewed where completed with clinical care conducted following an incident. For those residents who had sustained a possible head injury, e.g. skin tear or bruising, it was noted that a full set of neurological observations were not conducted. Staff record the incident in progress notes and the enrolled nurse has reviewed all forms for further investigation and sign off. The nurse manager advised that she also reviews all incidents, however, there is no record of this on the incident reports reviewed. One resident has developed a pressure injury but this had not been reported via the incident reporting process.	a) residents who have had an unwitnessed fall and possible head injury have not had a full set of neurological observations conducted following the incident; b) there is insufficient evidence to support that the nurse manager has reviewed all incidents and accidents for further follow up, investigation and analysis; c) one pressure injury sustained by a resident has not been reported via the incident reporting processes.	a) Provide evidence that neurological observations are completed fully for all suspected head injuries; b) provide evidence that the nurse manager reviews and conducts investigations for all incidents and accidents; c) ensure that any pressure injury is reported via the incident reporting process. 30 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing	PA Moderate	Education is provided at Ashlea Groves and there is a plan in place for 2015. Education provided in the latter half of 2014 included medication management, and a first aid refresher course. Previous certification finding around the provision of training for code of consumer rights, continence, manual	a) Educational needs identified at previous audit have not been provided including code of consumer rights, continence, manual	a) Ensure that staff receive training as per the 2015 education plan and as required; b)

education for service providers to provide safe and effective services to consumers.		handling, hoist use, and chemical safety continues to require improvement. The plan for 2015 includes these topics. Of the five staff files reviewed, annual performance appraisals have been conducted for one staff member with two staff not yet due for appraisal.	handling, hoist use and chemical safety; b) staff appraisals have not been conducted for all employees as required.	ensure that annual appraisals are conducted for all employees within the required time frames. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Aspects of the previous certification audit findings relating to medications administered with a corresponding order, review of standing orders, transcribing of medication orders and secure medication storage have been addressed and monitored. This was evidenced in the 14 medication charts reviewed, review of documentation, observation of practice and on discussions with staff. Medication charts are generated by the contracted pharmacy for GP's to sign. One medication chart was not signed by the GP. Two medication rounds were observed. One staff member did not check the medication chart against the medications prior to administering. Controlled drugs are stored securely. The controlled drug register evidenced that weekly checks had not been conducted, and four instances where staff had not completed signing of the register.	a) One resident medication chart was not signed by the GP; b) one staff member was observed not to follow correct administration procedure during a medication round; c) controlled drug register weekly checks have not been consistently conducted; and d) controlled drug register evidences incomplete entries of staff signatures on four occasions in the past six months.	a) Ensure that each medication chart is signed by the prescriber; b) ensure that staff follow correct administration procedures; c) provide evidence that weekly controlled drug register checks have been conducted; and d) provide evidence that controlled drug register entries meet the required standards and guidelines. 30 days
Criterion 1.3.3.1 Each stage of service provision (assessment, planning,	PA Low	Seven resident files were reviewed – four dementia and three rest home. There is documented evidence that one rest home and two dementia residents long term care plans were developed by the registered nurse manager, or the enrolled nurse – with sign off by the registered nurse. One rest home and one	One rest home and one dementia long term care plan has been developed by the enrolled nurse with no evidence of review and sign	Provide evidence that the registered nurse has input in to the development of care plans as per

provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.		dementia care plan developed by the enrolled nurse, have not been reviewed by the registered nurse manager. One rest home resident does not have a long term care plan (link #1.3.5.2) and one dementia resident is a respite resident. The registered nurse manager has completed training in InterRAI and has commenced utilising this assessment tool when reassessing residents.	off by the registered nurse manager	contractual requirements. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Previous certification audit identified that timeframes were not adhered to in regards to completion of assessments, care plans and care plan evaluations. Seven initial assessments and six initial care plans have been completed within the expected time frame for files reviewed. One initial care plan was not developed (link #1.3.5.2). Three of seven files sampled (one dementia and two rest home) identify that the long term care plan was completed within three weeks. Three permanent residents' long term care plans were not completed within expected timeframes (two dementia and one rest home is still to be completed). One respite resident has had an initial assessment and care plan completed. Evaluations of long term care plans has been conducted within the required time frames for those residents with a long term care plan.	Long term care plans were not completed within the required time frames for three residents – two dementia and one rest home.	Ensure that all aspects of assessments and care planning are completed within the time frames stipulated in the ARC contract. 60 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are	PA Moderate	In seven of seven files reviewed there is evidence that an initial assessment has been completed. Advised that one new resident is currently being assessed with the interRAI assessment tool. Further risk assessments including falls, pressure area, nutrition, continence, and pain are available for use and are evident in three files reviewed. Three residents do not have risk assessments completed and/or reviewed for all identified care issues.	a) risk assessments for three dementia residents have not been completed and/or reviewed – including i) nutrition, pain, falls, and pressure area; ii) falls, pressure area, pain and behaviours; and iii) falls.	Ensure that all required assessments are completed for all identified care issues.

documented to serve as the basis for service delivery planning.				30 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>On review of seven files there is evidence that six of seven residents had an initial care plan completed on the day of admission. One respite resident has an initial care plan in place. The service has addressed this aspect of the previous finding. Four permanent residents have a long term care plan in place. One new resident does not yet have a long term care plan, however, this is not yet due. One permanent resident does not have a long term care plan in place. Short term care plans were evident in files reviewed or changes had been made to the long term care plan where required. Activities plans were in place for four residents.</p>	<p>a) One permanent resident does not have a long term care plan in place. This was due for completion in early January 2015; b) one rest home and one dementia resident do not have an activities plan in place.</p>	<p>a) Ensure that all permanent residents have a long term care plan in place to guide care staff in the safe and appropriate delivery of care and services; b) ensure that all residents have an activities plan developed as per contractual requirements.</p> <p>30 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Moderate	<p>The interior of the building is generally well maintained with a home-like décor and furnishings. The corridors are wide with handrails in place. Residents were observed to safely mobilise throughout the facility. The dementia unit has a secure garden. One communal bathroom in the rest home area has a portion of the floor covering which has lifted and bubbled.</p>	<p>On a tour of the facility it was noted that a hazard identified via internal audit and previous certification audit remains unmanaged. A portion of the vinyl floor covering has lifted and bubbled and this remains a trip hazard to residents and staff.</p>	<p>Ensure that all hazards including the identified trip hazard in one rest home communal bathroom is appropriately managed.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.