

# Ashwood Park Lifecare (2012) Limited - Ashwood Park Retirement Village

---

## 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 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:

<b>Legal entity:</b>	Ashwood Park Lifecare (2012) Limited
<b>Premises audited:</b>	Ashwood Park Retirement Village
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 3 February 2016      End date: 4 February 2016
<b>Proposed changes to current services (if any):</b>	This audit has also included verifying six rooms that were previously part of the hospital and have now been included as part of the dementia unit as suitable for use within the dementia unit.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	117



# 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

Ashwood Park is part of the Arvida Group and provides cares for up to 121 residents requiring rest home, dementia or hospital level care and up to a further 35 residents requiring rest home level care in serviced apartments. On the day of the audit there were 117 residents including those in the serviced apartments. This audit has assessed six previous hospital level beds to provide dementia level care. These rooms are now located within the secure dementia unit. Two managers who previously owned the facility for four years are overseeing the service. The managers are well qualified and experienced for the role and are supported by a facility clinical manager, a clinical manager in each of the units and a quality manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff and management. This audit has identified areas for improvement around notifying families of incidents, wound management and restraint monitoring.

## 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 low risk.
--	--	---

Staff at Ashwood Park strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and 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.		Standards applicable to this service fully attained.
---	--	--

Ashwood Park has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Aspects of quality information are reported to two monthly combined staff and monthly quality meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at regular resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to

facility meetings. Ashwood Park has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing and health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. There is an improvement required around completing comprehensive documented wound assessments and documented timeframes for review/dressings. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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.
--	--	--

Ashwood Park has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. An authorised technician has calibrated medical equipment and electrical appliances. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas including sufficient space to cater for the extra residents in the extended dementia unit. There is a designated laundry and cleaner's rooms. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

## 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently 12 hospital level residents requiring restraints and 8 residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## 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 infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. 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. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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)
<b>Standards</b>	0	47	0	3	0	0	0
<b>Criteria</b>	0	98	0	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (seven healthcare assistants [one from the serviced apartments, two from the rest home, two from the hospital and two from the dementia unit], four registered nurses (RN) [two from the rest home and two from the hospital], the clinical manager from each unit, the activities lead and one activity officer, the quality manager and the facility clinical manager) confirmed their familiarity with the Code. Interviews with 12 residents (eight rest home and four hospital) and nine relatives (four from the dementia unit, four from the rest home and one from the hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings.</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>Informed consent and advanced directives were recorded as evidenced in the eleven resident files reviewed (four rest home, four hospital and three dementia). Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were</p>

		able to decline or withdraw their consent. Resident admission agreements were signed in all files sampled.
<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	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyers. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they are aware of advocacy and how to access an advocate.
<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	Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and relatives confirmed this and that visiting can occur at any time.
<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 service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents and relatives demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Verbal and written complaints are documented. Ten complaints from 2015 to date were reviewed. All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are fed back to complainants.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyers of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service, an RN or the clinical manager discusses the information pack with the resident and the family/whānau.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>A policy describes spiritual care. Church services are conducted in the facility every week. All residents and relatives interviewed indicated that resident's spiritual needs are being met when required.</p> <p>Staff interviewed were familiar with the policies and appropriate practices around the prevention and identification of abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan.</p> <p>Staff training includes cultural safety. The service is able to access Māori advisors as identified in the Māori health plan and policies. There were three Māori residents at the service and cultural needs were addressed in care plans sampled.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including residents cultural, beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect process covers harassment and exploitation. All residents</p>

		interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the health and disability services standards to meet the needs of residents requiring rest home, hospital level and dementia level of care. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and state that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were viewed. The form includes a section to record family notification. Not all forms indicated family were informed or if family did not wish to be informed. Relatives interviewed reported they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ashwood Park Hospital is part of the Arvida Group. The service provides dementia, rest home and hospital level care for up to 121 residents and rest home level care for up to a further 35 residents in serviced apartments. On the day of the audit there were 117 residents including 24 dementia residents, 53 rest home residents (including ten residing in serviced apartments and one on respite care) and 40 hospital level residents including two on long term chronic conditions contracts. As part of this audit, six rooms that were previously in the hospital unit and are now part of the dementia unit, have been assessed as suitable for use within the dementia unit.  The village managers have previously managed aged care facilities for nine years and owned Ashwood Park prior to the purchase by Arvida in

		<p>2014. The facility clinical manager has been at the service for two years, having previously held leadership and management positions within DHBs. She is supported by a clinical manager in each of the three units, all of who are qualified and experienced for the roles. Additionally the management includes a quality manager and an education coordinator. Ashwood CHT has a strategic plan and a quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The village managers have completed in excess of eight hours of professional development in the past 12 months.</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>In the absence of the village manager's manager, the facility clinical manager is in charge with support from the management team and care staff.</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>There is a quality plan that includes quality goals and risk management plans for Ashwood Park Hospital. There is evidence that the quality system continues to be implemented at the service. Interviews with staff confirmed that quality data is discussed at two monthly combined staff meetings to which all staff are invited. Additionally all quality data is comprehensively covered in the monthly quality meeting, and as part of the weekly clinical manager's meeting. The quality manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies have been reviewed regularly and updated to include InterRAI requirements. The management team reported that organisation wide Arvida policies are to be rolled out shortly.</p> <p>Resident/relative meetings are held. Restraint and enabler use is reported within the quality meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for 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. There</p>

		is a 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.
<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	There is an accidents and incidents reporting policy. The unit clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality and bi-monthly staff meetings including actions to minimise recurrence. Ten incident forms sampled documented clinical follow up of residents is conducted by a registered nurse. Discussions with the village managers confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with three appropriate section 31 notifications made since the previous audit and Public Health were appropriately notified of an outbreak.
<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	There are human resource management policies in place, which include that 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 is kept. Thirteen staff files were reviewed (the facility clinical manager, the quality manager, one unit clinical manager, one cleaner, two activity staff, four healthcare assistants and three registered nurses) and one these evidenced that reference checks are completed before employment is offered. This was completed for the only staff member employed in 2015 in the sample. The sample was extended to include eight further staff files for staff employed in 2015 or 2016 and all had reference checks, meaning the reference checking process has been embedded. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2015 has been completed and the 2016 programme is being implemented. There are 14 healthcare assistants who work routinely in the dementia unit and eight have completed the dementia standards. The remaining six have

		not been employed for one year. The clinical managers and registered nurses are able to attend external training including sessions provided by the local DHB. Fifteen of nineteen RNs are InterRAI trained. Annual staff appraisals were evident in ten of the staff files reviewed and the other three were new to the service.
<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>Policies include staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. There are two or three registered nurses rostered in the hospital on morning shift and two on the afternoon shift. There is one on night shift. Additionally there is a registered nurse rostered in the rest home on morning and afternoon shifts. There is also a clinical manager who works in each of the three units, Monday to Friday. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.</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>Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission. The service has specific information available for residents and family at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>The emergency policy outlines the procedures around transferring and</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>what has to occur, depending on the reason for transfer. The clinical manager is consulted prior to any resident transfer. All transfers to acute hospital services are reviewed at the clinical manager's weekly meeting. The transfer/discharge/exit procedures included a transfer/discharge form and the completed form is placed on file. The clinical managers stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation were forwarded with the resident. All admissions are reviewed during the weekly clinical meetings.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service uses individualised medication blister packs, which are checked in on delivery. Two registered nurses and a medication competent healthcare assistant were observed administering medications correctly in each area. The facility utilises the medi-map computerised medication management system. Access to medi-map medication charts and signing was secure and stored safely. All 22 medication chart signing sheets reviewed (a sample from each area) on medi-map reflected medications administered. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 22 medication charts reviewed. An annual medication administration competency was completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. No residents self-administered medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. 'As required' medication (PRN) was reviewed by a registered nurse each time prior to administration. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed.</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>	<p>FA</p>	<p>All meals at Ashwood Park are prepared and cooked on site. There is a four weekly rotating menu, which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room and served directly to rest home residents. Hospital and dementia unit residents have their own dining rooms with an adjacent kitchen servery. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Staff were observed</p>

		<p>assisting residents with their lunchtime meals and drinks. Diets are modified as required. Food services staff know resident dietary profiles, and likes and dislikes, and any changes are communicated to the kitchen, via the registered nurse or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a GP/dietitian. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p> <p>There are snacks available in the dementia unit at all times.</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 reason for declining service entry to residents to the service, would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family and the appropriate referrer.</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>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which forms the basis of resident goals and objectives. The 11 files reviewed identified that assessments have been reviewed at least six monthly, or if conditions changed. Appropriate risk assessments had been completed for individual resident issues. The InterRAI assessment tool was evident in all 11 resident files sampled and the care plans sampled demonstrated the assessment outcomes are used to inform care planning.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident files reviewed included all required documentation. The 10 long-term care plans (lifestyle plan) reviewed, included interventions to support current needs. The care plan reviewed of a resident on a LTC contract had specific needs addressed. A short-term care plan was in place for the respite resident. The service has a specific acute health needs care plan that included short term cares. Short-term care plans were noted to be in use where acute changes of health status were</p>

		identified in the resident files reviewed. Care plan interventions linked to risks identified in the InterRAI assessments. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>Turning charts and weight monitoring charts sighted indicated that appropriate interventions are documented as provided. Ongoing pain is documented as assessed and pain-monitoring charts are in use. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound monitoring and wound management plans are in place for 19 wounds including three pressure areas (link 1.3.3). Not all of these wounds have comprehensive assessments or a timeframe for review documented. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses, clinical managers and healthcare assistants demonstrated an understanding of the individualised needs of residents and report that two hourly turns occur. Food and fluid charts are comprehensively completed as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities staff provide an activities programme over five days each week for rest home and hospital level and seven days for dementia level. The programme is planned monthly and residents received a personal copy of planned monthly activities. Activities planned for the day were displayed on notice boards around the facility as sighted. A diversional therapy plan is developed for each individual resident based on assessed needs (sighted). Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings and two cars that are used for resident transport. Residents were observed participating in activities on the days of audit. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme</p>

		and the diversity offered to all residents.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations sampled were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Short-term care plans were in use. Care plans sampled were evaluated within the required timeframes.
<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	The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents and/or their family/EPOA are involved as appropriate when referral to another service occurs.
<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	All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts are available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.
<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 service displays a current building warrant of fitness, which expires 20 July 2016. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested and tagged, and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Healthcare assistants interviewed confirmed there was adequate equipment to carry out the care according to the resident needs as identified in the care plans.</p> <p>An internal door has been secured and the previous security moved from the existing door to convert six previous hospital rooms to dementia rooms within the secure environment. The rooms are suitable for</p>

		dementia level residents and there is a communal bathroom and shower in the corridor for the extra residents. Lounge, dining and outdoor areas are spacious enough to cater for the additional residents in the dementia unit.
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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	Some resident rooms in Ashwood Park include a full ensuite and others share communal toilets and showers. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs.
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	The resident rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Healthcare assistants interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms reviewed were personalised.
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large lounges and dining rooms in the rest home, hospital and dementia unit, and small seating areas, including a movie lounge. Serviced apartments include a lounge area. The dining rooms are spacious, and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></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	There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. The service has taken a proactive approach to facility hygiene and designated cleaners attend to specifically clean carpets weekly. There are secure cleaners cupboard with cleaners trolleys. Staff have attended infection control and safe chemical handling education and there was appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry

		service and cleanliness of the room/facility.
<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>The service has a fire and emergency procedures manual. There is an established current evacuation scheme. The service has documented a fire evacuation drill dated 19 November 2015, however, the maintenance manager stated that they have also completed three fire drills over the last month and fire safety training has been provided to ensure staff are fully aware. There is a staff member with a first aid certificate on each shift. A call bell light over each door and a panel in each corridor alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. There is a current emergency plan and the facility has the ability to remain self-sufficient in the event of an extreme emergency. Civil defence and first aid resources were available. There is sufficient food for at least three days, which is kept in the kitchen and rotated as required. There is a back-up generator, blankets, continence products, gas BBQs and torches. Sufficient water is stored for emergency use and alternative heating is available. Emergency lighting is installed. Security checks have been conducted each night.</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>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Ashwood Park Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the unit manager, the clinical coordinator and the infection control team. Minutes are available for staff. Infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>A registered nurse at Ashwood Park Hospital is the designated infection control (IC) coordinator. There are adequate resources to implement the</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>infection control programme for the size and complexity of the organisation. The IC nurse and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p><b>Standard 3.3: Policies and procedures</b> 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>There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>
<p><b>Standard 3.4: Education</b> The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p><b>Standard 3.5: Surveillance</b> 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>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at clinical managers/quality meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. An outbreak in May 2014 was appropriately managed.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b> Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were twelve residents with restraint and eight residents with an enabler. Enabler use is voluntary. All necessary assessments and evaluations had been completed in relation</p>

		to the restraints. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality meetings. The hospital clinical manager is the designated restraint coordinator.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The hospital clinical manager is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau, in the two files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the two restraint files and two enabler files reviewed, assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that did not always include regular two hourly monitoring were present, in the files reviewed. The service has a restraint and enablers register, which was up to date.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months. In the restraint files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at clinical management/quality meetings. Evaluation

		timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly clinical manager/quality meetings.

## 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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>The service has procedures where all incidents are reviewed by a registered nurse and the registered nurse reviewing the incident is delegated the responsibility to inform the family. Families interviewed believed they are well informed. The four incident forms sighted from the dementia unit and three from the rest home documented that family had been informed. This was not documented for the incident forms sampled from the hospital.</p>	<p>There was no documented evidence of family having been informed for three incidents sampled from the hospital.</p>	<p>Ensure family are informed of all incidents and that this is documented.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute</p>	PA Low	<p>There are sufficient dressing supplies and treatment rooms stocked for use. There are specific wound folders in each area that identify which residents</p>	<p>Sixteen of nineteen wounds did not have a current comprehensive wound assessment documented. Fifteen of nineteen wounds did not have the</p>	<p>Ensure that all wounds have detailed assessments documented. Ensure</p>

<p>to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>have wounds and a management dressing regime.</p>	<p>timeframe for the next review/dressing documented. This has been identified as low risk due to the wounds being managed appropriately, reviewed and evaluated at each dressing change.</p>	<p>that there is documented timeframes for reviews and dressings.</p> <p>60 days</p>
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	<p>PA Low</p>	<p>The two restraint files sampled included monitoring requirements (both two hourly) on the monitoring form and in the care plan. Monitoring forms were in place for both residents, but two hourly monitoring is not always documented.</p>	<p>The two restraint monitoring forms sampled did not consistently document the required two hourly monitoring.</p>	<p>Ensure restraint monitoring occurs within the designated timeframes and that this is documented.</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.