

Henderson Healthcare Limited - Edmonton Meadows Rest Home

Introduction

This report records the results of a Provisional 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:	Henderson Healthcare Limited
Premises audited:	Edmonton Meadows Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 March 2017 End date: 9 March 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	47

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.

General overview of the audit

Edmonton Meadows Rest Home is a privately owned aged care facility and cares for up to 60 residents requiring rest home and secure dementia care. On the day of the audit there were 47 residents.

A provisional audit was conducted to assess a prospective new owner for the facility and to assess the status of the service prior to purchase. This audit was conducted against the Health and Disability Service Standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff management and the prospective purchasers.

A manager (non-clinical) with 23 years' experience in aged care is the current facility manager. The facility manager is supported by an assistant manager and the registered nurses. The prospective owners advised that the facility manager and all other staff will be transferred to the new ownership. The prospective owners own three other aged care facilities in Auckland that provide rest home, hospital and dementia care. The prospective owners will continue to use the current Edmonton Meadows policies and procedures

to guide staff. It is the new owner's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The prospective owners have a plan for the transition and change of ownership.

This audit identified that improvements are required around interRAI assessments, care plan interventions, activities, medication management, food service and maintenance.

Consumer rights

Edmonton Meadows Rest Home provides care in a way that focuses on the individual resident. The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

Organisational management

Edmonton Meadows Rest Home is implementing a quality and risk management system that supports the provision of clinical care. Policies and procedures are maintained by an external quality advisor who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints and internal audits surveys. The health and safety programme meets current legislative requirements. There are human resources policies including recruitment, job descriptions, selection and orientation. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an annual education/training schedule. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

A registered nurse is responsible for the provision of care and documentation at every stage of service delivery. There is information gained through the initial support plans, specific assessments, discharge summaries and the care plans to guide staff in the safe delivery of care to residents. However, there is no interRAI assessment. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents at least three-monthly.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Nutritious snacks are available 24 hours.

Safe and appropriate environment

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There is a planned maintenance programme in place. Some residents' rooms have en-suites and there are sufficient communal showers/toilets for the others. Activities occur in the rest home in the spacious communal lounges. The dementia communal lounge is smaller but adequate for the smaller numbers of residents. External areas are safe and well maintained with shade and seating available. Cleaning and laundry services are monitored through the internal auditing system. Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The facility has ample natural light and ventilation.

Restraint minimisation and safe practice

The facility has a no or minimal restraint use philosophy. There is a restraint coordinator and restraint and safe practice policies and procedures in place. There are currently no restraints or enablers in use.

Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. The infection control coordinator has attended external education. 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. 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)
Standards	0	38	0	5	2	0	0
Criteria	0	86	0	5	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. Staff interviewed (one manager, one assistant manager, two registered nurses, eight caregivers and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent and resuscitation. Completed resuscitation forms were evident on all resident files reviewed. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed with the admission agreements.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. 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 and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interviews with residents demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints.</p> <p>There is a complaints' register. The manager reports that all verbal and written complaints are documented on the complaints' register. There were two complaints documented in the past 12 months. All complaint documentation was reviewed. All complaints had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. The manager advised that results are fed back verbally to complainants.</p> <p>Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns. One matter was referred to Health and Disability Commissioner and has now been investigated and closed.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code. Interviews with the seven rest home residents and three families (two rest home and one dementia) reported that the residents' rights were being upheld by the service.</p> <p>Interview with the prospective owners confirmed their understanding of the consumer rights and their obligations to ensure the Code of Health and Disability Services Consumers' Rights and the Nationwide Health and Disability Advocacy Service information is clearly displayed and easily accessible to anyone to whom the information is relevant to.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<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. The residents' personal belongings are used to decorate their rooms. All residents interviewed stated their needs were met.</p> <p>Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. The manager had dealt with one allegation of abuse made by a resident since the last audit and the staff member involved no longer worked at the facility.</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</p>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the</p>

individual and cultural, values and beliefs.		family/whānau in the day-to-day care of the residents. The service has access to a cultural advisor from the local Iwi Health Authority.
<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>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's 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. Staff receive training on cultural awareness.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. The staff files reviewed had job descriptions and employment agreements that have clear guidelines that describe the house rules. There are clear definitions of types of discrimination in the service discrimination policy sighted. Interviews with the caregivers confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey completed in April 2016 had only a 10% response rate. The residents that did respond reported satisfaction with the services that are provided. Residents are also provided with the opportunity to give feedback at the resident meetings which are held quarterly. The meeting minutes sighted evidenced that where improvements had been requested, where possible, these were actioned. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding</p>

		<p>of principles of aged care and stated that they feel supported by the management team.</p> <p>The prospective owners stated that they will continue with implementing best practice at Edmonton Rest Home.</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>There is a policy to guide staff on the process around open disclosure. Residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Ten incident forms randomly selected from the past three-month period identified family were notified following a resident incident. The manager and assistant manager confirm family are kept informed. Family members interviewed confirm they are notified of any incidents/accidents. Families are invited to attend the quarterly resident/family meetings.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Edmonton Meadows Rest Home provides care for up to 60 rest home level residents. On the days of audit there were 47 residents. There were 37 rest home residents including one resident admitted under a Long Term Chronic contract, one respite resident, one resident admitted under a young person with disability contract and one resident admitted under an ACC contract. There were 10 residents in the secure dementia unit. All other residents are admitted under the ARCC.</p> <p>The facility is being managed by a manager and an assistant manager who are both non-clinical. They coordinate and oversee the administration, quality activities and human resource management. Two full-time registered nurses (RN's) are responsible for clinical management and overseeing the clinical service. The manager and assistant manager have completed at least eight hours of professional development.</p> <p>Edmonton Meadows has an overall business 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</p>

		<p>statement.</p> <p>The prospective owners currently own three aged care facilities in the Auckland region that provide rest home, hospital and dementia care. All staff will be transferred to the new ownership including the manager and assistant manager. The prospective owners advised that no operational changes will be made. The manager will be required to report to the new owner's in the same manner that they reported to the previous owner. A transition plan has been developed in consultation with the current owners that will allow for a seamless transition for residents and staff. The prospective owners are aware of the requirements of the ARRC contract.</p> <p>The prospective owners have documented a business plan for Edmonton Meadows that will be implemented in conjunction with the current business and quality and risk plan in use. The business plans will be regularly reviewed. The prospective owners will be taking on directorship roles and the responsibilities for the directors have been documented. The tentative settlement date is late March 2017. Relevant authorities have been notified of pending change of ownership.</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>	<p>FA</p>	<p>Interview with the prospective owners and current management, informed that there will be no changes to the day-to-day operation of the facility. The two full-time RNs will continue to provide clinical oversight and after hours RN cover. The assistant manager supported by the RN's will cover the management of the facility in the event of the manager being away (confirmed in interview with the registered nurses and assistant manager). The prospective owners will be available to the staff 24 hours, 7 days a week.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Edmonton Meadows Rest Home has comprehensive policies/procedures to support service delivery. There is a documented process for reviewing organisational policies and procedures to ensure they align with current good practice and meet legislative requirements. The current 2017 quality plan describes the</p>

		<p>quality improvement processes for Edmonton Meadows Rest Home. The risk management plan describes objectives, management controls and assigned responsibility. The prospective owners advised they will adopt and continue to implement the current quality and risk management plan in conjunction with their business plan.</p> <p>There is a 2017 internal audit programme that covers all aspects of the service including environmental, food service, cleaning service, resident care and documentation. Corrective actions for partial compliance had been developed, implemented and signed off by the manager. A six-week post admission survey is included in the admission pack and the three returns (reviewed) from the past three months identified that no corrective actions were required. Resident meetings are held quarterly and provide residents with a forum for feedback on the services. The manager chairs the resident meetings.</p> <p>The manager is the health and safety officer and health and safety is an agenda item at the integrated staff meetings. There is a current hazard register which is reviewed six-monthly. Staff interview confirms they are kept informed on health and safety matters. There is a falls prevention and management policy in place and falls are addressed on an individual basis as part of the care planning process. There is a falls reduction programme in place for frequent fallers.</p> <p>Interview with the prospective owners confirmed the current quality management system and performance monitoring programme will continue following the sale. The manager and assistant manager will help mentor the prospective owners to the Edmonton Meadows quality and risk management system. There are no planned changes to the current policies and procedures.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incident and accident data has been collected, analysed and trended. Accident and incident data</p>

<p>manner.</p>		<p>and the actions to minimise recurrence is discussed at staff meetings. The manager advised they are responsible for investigating accidents and near misses.</p> <p>A sample of ten resident related incident reports randomly selected from the past three-month period were reviewed. All of the incident reports sampled (and a review of the clinical files), evidenced that appropriate clinical assessments, care and care plan documentation had occurred following the incident. All of the accident and incident forms reviewed evidenced the family/whānau had been notified of incident.</p> <p>Discussions with the manager and the prospective owners confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. The service has a process/policy that reflects the Health and Disability Services (Safety) Act 2001 section 31 reporting guidelines.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Six staff files sampled (one manager, one registered nurse, an activities coordinator, a chef, one caregiver, one cleaner) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the RNs. Two of the two registered nurses have completed interRAI training. There is a minimum of one staff member trained in first aid and CPR rostered on each shift.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Staff complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements and this is being implemented. The RNs and caregivers complete an annual medication competency and attended medication education in August 2016.</p>

		<p>Ten of twelve caregivers who work in the dementia unit have completed their New Zealand Qualification Authority (NZQA) approved dementia qualification. The remaining two caregivers have been employed less than one year and are enrolled.</p> <p>The manager and registered nurses are able to attend external training, including sessions provided by the local DHB.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. In the rest home (thirty-seven residents), there are three caregivers and one registered nurse rostered on a morning shift and four caregivers rostered on for an afternoon shift. In the dementia unit (ten residents) there are two caregivers rostered on for a morning and afternoon shift. The night shift is staffed with two caregivers in the rest home and one caregiver in the dementia unit. The registered nurses share the on call. Caregivers interviewed confirmed the RNs are readily available after hours. Extra staff can be called on for increased resident requirements.</p> <p>There are dedicated laundry and cleaning staff seven days per week. The activities team provide cover five days per week.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. The manager is also on call 24 hours per day, 7 days a week.</p> <p>The prospective owners stated in the interview that there is no intention for them to make any changes to the roster and all current staff will be transferred over to the prospective owners on the date of settlement. The current manager and assistant manager will continue to look after the day-to-day management of the service and the implementation of the quality and risk programme. The prospective owners will also be available to staff 24 hours per day, 7 days a week.</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>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.</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>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy.</p> <p>The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Seven admission agreements viewed were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</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>PA Low</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit.</p> <p>The facility uses a robotic pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses or caregivers who have passed their medication competency administer medications. Medication competencies are updated annually and staff attend annual education. There are no standing orders. The medication fridge temperature is checked weekly. Eye drops are not always</p>

		<p>dated once opened.</p> <p>Staff sign for the administration of medications electronically. Controlled drugs are checked out by two people. The DDA register is checked weekly.</p> <p>Fourteen medication charts were reviewed electronically. Medications are reviewed at least three-monthly by the G.P. There was photo ID and allergy status recorded electronically. As required medications had prescribed indications for use.</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>PA Low</p>	<p>The service employs one chef and one kitchen hand Monday to Friday and one cook and one kitchen hand at the weekend. There is also an evening kitchen hand. All have current food safety certificates. The week day chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from a bain marie in the kitchen to the rest home dining room and from a bain marie in the dementia unit. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen staff do not wear hats for meal preparation. Food satisfaction is included in a general satisfaction survey. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked before food is served. These were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The menus have been audited and approved by an external dietitian. Most residents and families interviewed were happy with the meals provided at every mealtime. There was evidence that there are additional nutritious snacks available over 24 hours.</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>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>Edmonton Meadows initial assessment and risk assessments were completed for falls risk, pressure injury risk, nutritional, pain and continence. This information is used to develop the care plan. Additional assessments for management of wound care and cultural needs were appropriately completed according to need. Pain assessments were completed on admission and evaluated six-monthly or as necessary if a resident's pain changed. Some residents with episodes of aggressive behaviour had assessment and behaviour charts completed. Two of two registered nurses are trained in the use of interRAI. There were no interRAI assessments completed in all seven files sampled. The sample was extended by four files and none of those four had an interRAI assessment (link 1.3.3.3). No interRAI assessments have been completed when there has been a significant change in a resident's health status.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. Four of seven care plans reviewed included documentation that meets the need of the residents and care plans had been updated as residents' needs changed. Three care plans reviewed had no interventions documented re absconding and aggression or the documentation lacked sufficient detail. Rest home residents interviewed stated they were involved in the care planning process.</p> <p>Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There was evidence of service integration with documented input from a</p>

		range of specialist care professionals including the podiatrist, wound care nurse, geriatrician and mental health care team for older people.
<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>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Changes in care are documented on short-term care plans and communicated at handovers. Staff state that they notify family members about any changes in their relative's health status. Rest home residents state care delivery and support by staff is consistent with their expectations.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound management and monitoring occurred as planned. There are currently three wounds (one squamous cell carcinoma, one chronic venous ulcer and one ulcer on a left heel). All wounds have appropriate care documented and provided. The cancer lesion has had specialist attention and the WDHB wound care nurse has had input into the care of the chronic ulcers. There are also photos of the chronic ulcers progress.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</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>	PA Low	<p>There is one activities coordinator who works 40 hours a week and one activities assistant who works 15 hours a week. The activities coordinator has completed Health Ed Trust aged care modules and the activities assistant has completed some aged care modules and art courses. On the days of audit, residents in the rest home were observed being actively and enthusiastically involved with a variety of activities including exercises, singing along with an entertainer and playing bowls. Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need. The local library visits monthly.</p>

		<p>There is a large print copy of the monthly programme on the noticeboard in the rest home and the daily programme is written up on a whiteboard. The dementia unit does not have a separate programme, though those able may join in rest home activities.</p> <p>In the rest home, there are weekly Catholic Church services and a monthly interdenominational service. Some dementia unit residents join these services and some residents go out to church on a Sunday with family members.</p> <p>In the rest home, there are van outings twice weekly and in the dementia unit once weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present activity plan that covers the 24-hour period. Activity plans are evaluated six-monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The seven care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. All long-term care plans reviewed had a documented evaluation completed. Short-term care plans for short term needs were evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each resident and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where one resident had been referred to the skin specialist and another to the</p>

<p>to meet consumer choice/needs.</p>		<p>mental health team for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are clear policies regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas in all areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff. The maintenance person described the safe management of hazardous material.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building holds a current warrant of fitness which expires 10 October 2017.</p> <p>There is a planned maintenance programme in place. Reactive and preventative maintenance occurs. Some areas in the showers and toilets that require maintenance have not been attended to in spite of being written up in the maintenance book.</p> <p>Electrical equipment has been tested and tagged. The sling hoist has been checked and tagged. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges are carpeted. The hallways and utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms, ensuites and communal showers and toilets have non-slip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. The dementia unit</p>

		has a secure outdoor area. There is safe access to all communal areas.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	There are a small number of rooms with ensuites in the rest home. Those without share communal showers and toilets. In the dementia unit, all showers and toilets are communal. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning (link 1.4.2.1). There is ample space in all toilet and shower areas to accommodate shower chairs and hoists if appropriate.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	Residents' rooms are spacious and allow care to be provided and the safe use of mobility aids. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Activities occur in the rest home in the spacious communal lounges. The dementia communal lounge is smaller but adequate for the smaller numbers of residents. All lounges are large enough to not impact on other residents who are not involved in activities. Seating and space is arranged to allow both individual and group activities to occur. There are areas where residents who prefer quieter activities or visitors may sit. The dining rooms are also spacious and the décor is attractive and homely.
<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	All laundry is undertaken on-site. The laundry is small but well organised and is divided into a "dirty" and "clean" area. The laundry staff member interviewed stated that she manages the workload well. There are appropriate systems for managing infectious laundry which the laundry staff member could describe. There is a comprehensive laundry and cleaning manual. Cleaning and laundry services are

		<p>monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in a room off the laundry as sighted on the day of the audit. Cleaning is done by an on-site cleaner with assistance from extra cleaning staff every Friday. There is one sluice room for the disposal of soiled water or waste. The sluice room and the laundry are kept locked when not in use.</p>
<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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. A gas barbeque is available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Residents interviewed advised that their call bells are answered promptly.</p> <p>There is a minimum of one staff available 24 hours a day, 7 days a week with a current first aid/CPR certificate.</p> <p>The staff are responsible for checking the facility for security purposes on the afternoon and night shifts. A surveillance camera is set up internally throughout the facility.</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>The facility has ample natural light and ventilation. There is heating in the roof area throughout the facility. Staff stated that this is very effective. The facility is smoke-free.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>Edmonton Meadows Rest Home has an established infection control programme. The infection control programme, its content and detail,</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>		<p>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 infection control team and all other staff. Spot 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> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>A senior registered nurse at Edmonton Meadows Rest Home is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the manager, the assistant manager, laundry, staff and senior caregivers) have good external support from the GP and external infection control consultant. 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>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Edmonton Meadows Rest Home infection control policies and procedures are appropriate 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>Standard 3.4: Education</p> <p>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 attends external training on infection prevention and control and is provided with education and updates through this forum. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to</p>

		residents and visitors that is appropriate to their needs and this is documented in medical records.
<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 is an integral part of the infection control programme and is described in Edmonton Rest Home's 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 integrated staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The facility has a no or minimal restraint philosophy. There are restraint minimisation and safe practice policies and procedures in place. There is a restraint and enabler register. There is a designated restraint coordinator. When interviewed, the restraint coordinator reiterated the facility's no or minimal restraint philosophy. There are currently no restraints or enablers in use.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Low	There are comprehensive policies and procedures in place to meet all aspects of medication management. Staff administering medications follow recognised guidelines, however, they were not dating eye drops on opening to ensure they were discarded after 28 days.	Five of six eye drops checked had not been dated when opened.	<p>Ensure all eye drops are dated when opened.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. The kitchen complies with current legislation and guidelines except for kitchen staff not wearing hats for food preparation.	Hats are not worn in the kitchen for food preparation.	<p>Ensure hats are always worn in the kitchen for food preparation.</p> <p>30 days</p>

<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>Seven resident files were reviewed (two dementia, five rest home including one 1 young person with disability (YPD), one long term chronic and one respite). All seven long-term care plans identified that a registered nurse has undertaken an initial assessment (Edmonton Meadows form) and had developed long-term care plans within the required timeframes. All long-term care plans had been evaluated six-monthly or more often as needed.</p> <p>Medical assessments were completed on admission by the general practitioner (GP). All files reviewed evidenced at least three-monthly GP reviews.</p>	<p>InterRAI assessments have not been completed within the required timeframes. Eleven files reviewed identified no interRAI assessments completed.</p>	<p>Ensure interRAI assessments are completed within the first three weeks of admission, reviewed at least every six months and/or updated following a significant change in a health condition.</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>Edmonton Meadows initial assessment and risk assessments were completed for falls risk, pressure injury risk, nutritional, pain and continence. This information is used to develop the care plan. Additional assessments for management of wound care and cultural needs were appropriately completed according to need. Pain assessments were completed on admission and evaluated six-monthly or as necessary if a resident's pain changed.</p>	<p>While assessments are completed, the service is not meeting ARC D15A and ARC E4.2b</p>	<p>Ensure the ARC contract is being met in regards to completing interRAI assessments.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention</p>	<p>PA Moderate</p>	<p>Three care plans reviewed had no interventions documented re absconding and aggression or the documentation lacked sufficient detail. Some residents</p>	<p>Interventions were not documented or documented in sufficient detail for three residents</p>	<p>Ensure interventions are documented to include de-escalation techniques to manage episodes of</p>

to achieve the desired outcomes identified by the ongoing assessment process.		with episodes of aggressive behaviour had behaviour charts completed and information from these was used to inform the care plan.	following episodes of absconding and aggression.	absconding and aggression. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	The rest home activities programme is comprehensive, full of variety and meaningful to the residents. A small number of dementia unit residents are able to join this programme if they wish. The activities assistant works in the dementia unit once a week mainly doing arts and craft. At other times the caregivers may initiate a sing-a-long or dancing. One resident complained of feeling bored. There is no group activity programme to meet the needs of the residents in the dementia unit.	There is no planned group activities programme in the dementia unit to meet the needs of dementia residents.	Commence a planned group activities programme in the dementia unit to meet the needs of dementia residents. 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There is a planned maintenance programme. Reactive and preventative maintenance occurs. Some areas in the showers and toilets have work that requires remedial attention. This has not been completed in spite of being written up in the maintenance book.	Two showers requiring maintenance; one has split vinyl and one has chipped paint on skirting boards exposing raw timber. The vinyl in the dementia toilet is split and coming away from the wall.	Ensure remedial work in the showers and toilet is completed. 60 days

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.