# Elsdon Enterprises Limited - Ashlea Grove Rest Home

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Elsdon Enterprises Limited

**Premises audited:** Ashlea Grove Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 1 August 2017 End date: 2 August 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:** 33

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

## General overview of the audit

Ashlea Grove rest home is certified to provide rest home and dementia level care for up to 35 residents. On the day of audit there were 33 residents. The proprietors have owned/managed Ashlea Grove rest home for four years. Two owner/managers (husband/wife) have the responsibility of the daily operations, finance and maintenance, and to oversee the delivery of services. The owner/managers are supported by a part time clinical lead/RN.

The audit process included a review of policies and procedures, the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

Residents and family members interviewed praised the service for the support provided.

Improvements are required around monitoring timeframes for neurological observations, interRAI assessments, documentation in progress notes, medication administration, and hot water temperatures.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The staff at Ashlea Grove rest home 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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan and quality plan have goals documented. There are policies and procedures to provide appropriate support and care to residents with rest home and dementia level needs. There is a documented quality and risk management programme that includes analysis of data.

Ongoing training is provided and there is a training plan developed and implemented for 2017. Rosters and interviews indicate sufficient staff that are appropriately skilled with flexibility of staffing around clients’ needs.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. Residents and family interviewed confirmed that they were happy with the care provided and the communication. Planned activities are appropriate to the residents assessed needs and abilities and residents advised satisfaction with the activities programme.

There is a documented medication management system at the facility. There is a three-monthly general practitioner review. Residents' food preferences and dietary requirements are identified at admission and all meals cooked on-site. The kitchen is well equipped for the size of the service. 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. At the time of the audit there were no residents using restraint or enablers.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer (the registered nurse). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends.

## 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 | 41 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 88 | 0 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with staff (three caregivers and two diversional therapists) confirmed their familiarity with the Code. Five rest home residents and four family members (three rest home and one dementia care level) interviewed, confirmed the services being provided are in line with the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. A multipurpose informed consent form is utilised by the service provider and is retained in each individual resident’s record reviewed. Forms sampled were signed and dated appropriately. The admission agreements were signed and dated by the provider and the resident and/or representative. Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Interviews with residents confirmed that the service actively involves their relatives in decisions that affect their lives, where they consent to this. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Contact numbers for advocacy services are included in the resident information folder and in advocacy pamphlets that are available around the facility. Discussions with residents identified that the service provides opportunities for the family/EPOA to be involved in decisions. The service has links to the local Alzheimer’s Society which provides support for those who have dementia or have a loved one with a diagnosis of dementia. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents confirmed that visiting can occur at any time. Key people involved in the resident’s life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy and procedures in place and residents and their family/whānau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A review of the complaints log/register evidences that four complaints had been made since the last audit. The service had three complaints made in 2015 and one complaint received in 2016. Appropriate actions have been taken in the management and processing of the complaint. A complaints procedure is provided to residents within the information pack at entry. Residents and family members advised that they are aware of the complaints procedure and how to access complaint forms. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy including in formats suitable for people with intellectual disabilities. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents interviewed identified they are well informed about the Code. Surveys and direct communication with management provide the opportunity to raise concerns. Advocacy and the Code information is included in the information pack and are available at the service. The information pack also includes information about the dementia care unit, the need for a secure environment and behaviours that may be observed. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed could describe the procedures for maintaining confidentiality of resident records, residents’ privacy and dignity. House rules are signed by staff at commencement of employment. Residents are supported to attend church services held within the facility or attend church services in the community if they wish. Residents interviewed reported that they can choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education around this occurred in July 2017. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The service has a Māori heath plan and an individual’s values and beliefs policy, which includes cultural safety and awareness. There were no residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff had training around cultural awareness in October 2016. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs and supported to maintain these. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries. All staff have completed training around professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service meets the individualised needs of residents who have been assessed as requiring rest home or dementia level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Combined quality/staff meetings are conducted every three months. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Caregivers complete competencies relevant to their practice. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Relatives interviewed confirmed they are notified following a change of health status of their family member. This was confirmed in twelve incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur quarterly and management have an open-door policy. The residents stated that the owner/managers are on-site daily and visit residents to ask about their wellbeing. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Elsdon Enterprises (Ltd) are the proprietors of Ashlea Grove rest home in Milton. The organisation has three other facilities. The service can provide care for up to 35 residents, (20 rest home and 15 dementia level care). On the day of the audit there were 33 residents in total, 19 of 20 rest home (including one rest home resident on respite), and 14 of 15 dementia level residents (including one dementia resident on respite). All permanent residents were under the Aged Residential Care (ARC) contract.  The proprietors have owned/managed Ashlea Grove rest home for four years. Two owner/managers (husband/wife) have the responsibility of the daily operations, finance and maintenance, and to oversee the delivery of services. The owner/managers are supported by a part-time clinical lead/RN. The clinical lead/RN has been in the role since October 2015. She is supported by a part-time registered nurse (RN) with experience in aged care. Both have a current annual practicing certificate.  The service has a business plan for 2016 – 2019. The mission statement sets out the vision and values of the service, and is included in the information booklet. This is given to each resident and family on admission. An organisational chart visually describes reporting relationships for the management structure. The owner/managers’ report to the governing board on a monthly basis and on a variety of topics relating to quality and risk management.  The owner/managers have attended at least eight hours of training relating to managing a rest home including attendance at aged care provider meetings. |
| Standard 1.2.2: Service Management  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. | FA | During the temporary absence of the owner/managers, the care lead/RN will fill the role with support from the RN. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The owner/manager facilitates the quality programme and ensures the internal audit schedules are followed. Corrective action plans are developed and signed off when service shortfalls are identified. Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Quality improvement data is discussed at monthly combined quality/staff meetings. Resident meetings have been held regularly every three months.  There are policies and procedures provided by an external aged care consultant that are relevant to the service types offered and these are reviewed and updated at least two yearly or sooner if there is a change in legislation, guidelines or industry best practise. There is a current risk management plan. Hazards are identified, managed and documented on the hazard register. There is a designated health and safety officer (the co-manager). Health and safety issues are discussed at monthly quality/staff meetings with action plans documented to address issues raised.  There are resident/relative surveys conducted and analysed annually. The June 2017 resident/relative survey had been distributed. The survey evidences that residents and families are overall very satisfied or satisfied (98%) with the service. A falls prevention group has recently been set up to focus on minimising the risk of each resident falling and enable efficient management of falls and residents who fall frequently. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The dementia care unit also has a refurbished dining room with tables without legs to help minimise falls. |
| Standard 1.2.4: Adverse Event Reporting  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. | PA Low | The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Twelve incidents reviewed (all incidents from July 2017) demonstrated clinical follow-up. However, not all neurological observations were completed for resident falls with a potential head injury. Accidents and incidents are analysed monthly with results discussed at the combined quality/staff meetings. The management team are aware of situations that require statutory reporting. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files sampled (one clinical lead/RN, one RN, two caregivers, one cook and one housekeeper) show appropriate employment practices and documentation. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. Current annual practising certificates are kept on file.  The orientation package provides information and skills around working with residents with rest home and dementia level care needs and were completed in all staff files reviewed. There is an annual training plan in place for 2017. There were sixteen caregivers that work in the dementia care unit; eleven had completed the required dementia standards and four were in progress of completing.  The four yet to complete the qualifications have been employed within the past 12 months. Residents interviewed stated that care staff are knowledgeable and skilled. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The owner/managers are both on-site 40 hours per week. The owner/managers are on-call after hours for any non-clinical issues and the clinical lead/RN on call for any clinical issues. The local general practitioner (GP) also provides after-hours care if required and caregivers have access to the local ambulance service. Interviews with caregivers, residents and family members identify that staffing is adequate to meet the needs of residents. Advised that extra staff can be called on for increased resident requirements.  There is an RN on-site on the morning shift during weekdays (one RN works Mon-Tues and the clinical lead works Wed- Fri). In the rest home (19 residents) there is one caregiver (full shift) on the morning shift, one caregiver on the afternoon shift and one on the night shift. There is an additional caregiver on duty in the morning and afternoon shifts to assist with the morning breakfast, evening meal and cover for staff meal breaks. In the dementia care unit (14 residents) there are two caregivers (various times) on the morning shift, two on the afternoon shift (various times) and one on the night shift. Staff and residents interviewed, confirmed that staffing levels are adequate and that management are visible and able to be contacted at any time. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so. Individual resident files demonstrate service integration. Entries are legible, dated and signed by the relevant staff member including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement. Admission agreements were signed in all resident’s records sampled. Residents and families reported that the admission agreements were discussed with them in detail by the owner/manager. All residents had the appropriate needs assessments prior to admission to the service. The service has specific information available for residents/families/EPOA at entry and it included associated information such as the Code, advocacy, complaints procedure and information about the dementia care unit. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. The RN verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medication policies align with accepted guidelines. The RNs and caregivers responsible for the administration of medications have completed annual competencies and medication education. The administration of medications observed during the lunchtime medication round did not fully comply with the medication administration policies and procedures. Medication reconciliation signing evidenced medications are checked on arrival by the RN. Any pharmacy errors are recorded and fed back to the supplying pharmacy. Standing orders were in use and had been reviewed by the GP.  Medications requiring refrigeration are stored appropriately and the fridge temperature is monitored daily and is maintained between 2-8 degrees Celsius. Ten medication charts were reviewed. All medication charts had photo identification and allergy status. All charts evidenced three monthly GP reviews. All medication charts documented the indications for use of ‘as required’ medications. Gaps were identified in the administration signing charts. There were no residents who self-administered medications. The self-administration policies and procedures were in place. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All food is prepared and cooked on-site at Ashlea Grove. There are two cooks that cover the seven-day week. They have completed food safety NZQA unit standards. The service provides meals on wheels to the community and the local district council has completed a safety check and issued a compliance certificate in July 2017. There is a caregiver on duty in the afternoons to present the evening meal. There is a four-weekly rotating menu that has been reviewed by a dietitian in August 2016. Hot food meals are placed in preheated serving dishes and transported to each dining room. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated.  The meals were well-presented and residents confirmed that they are provided with alternative meals as per request. There is food available 24-hours per day in the dementia care unit. Fridge temperatures are recorded weekly and freezer temperatures are recorded monthly. Food temperatures had been taken and recorded daily. A cleaning schedule is maintained. Expiry dates are documented on storage containers when food was evidenced to have been decanted from the original container. All residents are weighed at least monthly. Residents with weight loss are provided with food supplements. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | Ashlea Grove records the reason for declining entry to prospective residents should this occur and communicates this to prospective residents/family/whānau and refers the prospective resident/family/whānau back to the referral agency. The reason for declining entry would be if there were no beds available or the service could not meet the assessed level of care. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | 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 formed the basis of resident goals and objectives. Assessments are reviewed at least six-monthly. Appropriate risk assessments had been completed for individual resident issues. The RN has completed interRAI training and the assessment tool was evident in resident files (link 1.3.3.3). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans (LTCP) sampled were completed within three weeks of admission and were resident-focused and personalised. Interventions included support for current needs. Short-term care plans are developed where needed and were evident in the sampled files. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Families interviewed confirmed their involvement in the care planning process. Short-term care plans are in use for short-term needs and changes in health status. Staff members reported they are informed about changes in the care plans. Integration of records and monitoring documents are well managed. The respite resident file included an initial assessment/care plan and also a LTCP. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Care plans are current and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with staff (RN and caregivers) and relatives confirmed involvement of families in the care planning process. Caregivers and the RN interviewed stated there is adequate equipment provided including continence and wound care supplies. Visual inspection confirmed that continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.  Specialist continence advice was available as needed and this could be described. Wound assessment and wound management plans were in place for two residents and evidenced that all required documents were fully completed. Behavioural description records are used for residents that exhibit new or different from usual challenging behaviour. Established patterns of challenging behaviour are documented in the progress notes. Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The two diversional therapists work a total of 26.5 hours per week, sharing their time between the dementia care unit and the rest home. The programme is planned over a seven-day week and times vary according to the activity. The programme is planned monthly and additional activities including garden walks, are supported by the caregivers. Activities planned for the week were displayed on noticeboards around the facility and included craft (making wheat bags), baking, gentleman’s club meetings, manicure and foot spa treatments, praise be sessions and van trips to the local RSA. An individual assessment and activities plan has been developed for each individual resident, based on assessed needs. Daily attendance and evaluation of attainment towards meeting goals is documented.  Residents in the dementia care unit have appropriate activities documented over the 24-hour period. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities such as visits to and from local kindergarten, primary and high school, and to twice-weekly community eldercare group meetings. Residents were observed being encouraged and participating in activities on the days of audit. Monthly resident meetings and the next of kin surveys provide a forum for feedback relating to activities as well as resident verbal feedback. Family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans were reviewed and evaluated every six months or earlier as required in files sampled. The interventions in both long-term and short-term care plans were modified when the outcomes are different from expected. Recent reassessments have been completed using the interRAI tool. The interviewed residents and family members reported they were involved in all aspects of care and reviews/evaluations of the care plans.  The family are notified of GP visits and three-monthly reviews by phone call and if unable to attend, they are informed of all the changes. There is at least a three-monthly medical review by the medical practitioner. In files sampled, short-term care plans were consistently developed when acute conditions are identified. This included (but not limited) wounds, UTIs and chest infections. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. Internal referrals are facilitated by the RN. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | All chemicals were securely stored. Storage areas both inside and outside were locked. Chemicals were clearly labelled and safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required.  Review of staff training records and interviews with caregivers, laundry and cleaning staff confirmed that regular training and education on the safe and appropriate handling of chemical and waste, and hazardous substances occurs. The chemical supply company visits each month to check that supplies are adequate and that staff are managing chemicals safely and efficiently. The owner is responsible for maintenance and at interview had a good knowledge of the responsibilities associated with this role in the organisation. Waste management systems meet legislative requirements. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Handrails are installed in corridors, showers and toilets to promote safe mobilisation. The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is appropriate and secure, bathroom floors are non-slip, and walking areas are not cluttered. Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety test tag systems show this has occurred. Clinical equipment is tested and calibrated by an approved provider at least annually or when required.  The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. The current building warrant of fitness expires on 12 July 2018. The hot water temperatures are monitored monthly. Review of the records reveals temperatures are above required standards. This was addressed during the audit. All external areas inspected were safe and secure, and contain appropriate seating and shade. There is a secure outside area off the dementia care unit. There is a keypad lock system to entrance and exit doors in the dementia care unit. There are external gardens and seating available for rest home residents. Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are sufficient numbers of toilets and bathrooms for the number of residents in the rest home and the dementia care unit. Privacy is maximised in both care settings. All bathrooms and toilets are maintained to a good standard, are disability accessible with easy to clean walls and floors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. There is adequate space in both care settings. Residents can personalise their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The dementia care unit has a refurbished dining room with tables without legs (attached to the wall) to minimise falls and a sunroom lounge with external access. There is adequate room for facilitating activities. Appropriate comfortable seating is provided and a quiet room is available for use. The main lounge in the rest home is a combined dining room lounge and is used for functions and activities. Dining rooms and lounges are within easy walking distances to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet time. All furniture is safe and suitable for the resident groups in each care setting. The owner/managers, residents and staff reported that a continuing refurbishment programme is in progress and includes all communal areas. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Care staff are responsible for laundry and cleaning services. There is a large laundry with a clean and dirty flow. Cleaning chemicals are securely stored. Current safety material datasheets about each product are located with the chemicals in each area of service. The cleaner’s trolley is stored in a locked room when not in use. The residents and their families confirmed they were happy with laundry services. A visual inspection confirms the laundry and cleaning processes are implemented. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an emergency management plan to guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan. Fire evacuation drills are completed every six months. A contracted service provides checking of all facility equipment including fire equipment. Civil defence supplies are checked six-monthly with the last check occurring in April 2017. The facility has back-up lighting, power and sufficient food and personal supplies to provide for its maximum number of residents in the event of a power outage.  There is also sufficient water stored to ensure for three litres per day for three days per resident. There are alternative cooking facilities available with a gas barbeque and gas cooker. The staff are responsible for checking the facility for security purposes on the afternoon and night shifts. The police would be summoned if/when required. The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas. There is a staff member on each shift with a current first aid certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The rest home and dementia care unit have adequate heating with wall hung radiators throughout. Individual rooms are heated with adjustable radiators. The owner (maintenance person) interviewed ensures the heating systems are running smoothly and that appropriate checks are performed. On the day of audit, the indoor temperature was comfortable. There are sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows which are designed and installed to promote ventilation and to be secured as needed. The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months. |
| Standard 3.1: Infection control management  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. | FA | Ashlea Grove has an established infection control programme. The infection programme is appropriate for the size, complexity and degree of risk associated with the service. The RN is the designated infection control person with support from all staff. Infection control matters are routinely discussed at all quality/staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme. The RN is responsible for infection prevention and control. The infection control team is all staff through the quality/staff meeting. External resources and support are available when required. 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. |
| Standard 3.3: Policies and procedures  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. | FA | The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The staff orientation programme includes infection control education. The infection control person has completed infection control updates and provides staff in-service education which last occurred in January 2017. Education is provided to residents during daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 compared month by month. Outcomes and actions are discussed at quality/staff 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 owner/managers. The infection rate is very low and there have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. The service philosophy includes that restraint is only used as a last resort. At the time of the audit there were no residents using restraint or enablers. Staff have been trained in restraint minimisation and the management of behaviours that challenge, last occurrence in July 2017. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Twelve incidents (all incidents from July 2017) demonstrated clinical follow-up. However, not all neurological observations were completed for resident falls that resulted in a potential head injury. | Twelve incident forms were reviewed in total. Four incident forms were reviewed for resident falls with a head injury. The neurological observations forms completed were not all fully completed. | Ensure that neurological observations are fully completed for any resident with a potential head injury.  60 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The service has appropriate policies and procedures around medication management, storage and administration. All medications were stored appropriately. Administration procedures including signing for medications were not always followed. | (i) There was evidence of gaps in two signing sheets (one eye drops) and an incorrect signing in one other (eye drops). (ii) Staff were observed not following policy and procedures during medication administration. | (i) Ensure all medications are administered as prescribed. (ii) Ensure that medication administration policies and procedures are implemented by staff.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Long-term care plans for all residents were completed and reviewed as per contractual requirements. Short-term care plans are completed when required. All interRAI assessments are current. However, not all initial interRAI assessments were completed within contractual timeframes an completed before the LTCP. | Three of six files reviewed (two rest home and one dementia) admitted after 1 July 2015, did not have an initial interRAI assessment completed within 21 days. | Ensure an interRAI assessment is completed for all new residents within 21 days and this informs the LTCP.  90 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Caregivers document progress notes daily and files sampled evidenced that progress notes were completed by the RN after GP visits. However, there were significant periods in the progress notes where no RN review was documented. | All six files sampled had significant periods (some of over four weeks) where there was no RN documentation in the progress note. | Ensure that all residents are reviewed regularly by a RN and that this is documented.  90 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | The interior of the building is maintained with a home-like décor and furnishings. The corridors are wide, with handrails in place. Residents were observed to safely mobilise throughout the facility. All communal bathrooms have been upgraded. Hot water temperatures are recorded in rotating locations throughout the facility on a monthly basis, however these have consistently been above 45 degrees. | Hot water temperatures are consistently above 45 degrees Celsius. On the day of audit this was addressed and the temperatures were below 45 degrees | Ensure all hot water temperatures are maintained at 45 degrees or lower.  30 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.