Elsdon Enterprises Limited - Ashlea Grove Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Elsdon Enterprises Limited
Premises audited:	Ashlea Grove Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 April 2019 End date: 17 April 2019

Proposed changes to current services (if any): The service has increased their dementia level beds from 15 to 17 by reconfiguring 2 single rooms as double rooms.

Total beds occupied across all premises included in the audit on the first day of the audit: 35

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ashlea Grove rest home is certified to provide rest home and dementia level care for up to 37 residents. On the day of audit there were 35 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 and long-standing staff.

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

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

The service has addressed the five previous audit shortfalls around neurological observations, timeframes, documentation in progress notes, medication administration, and hot water temperatures.

This audit has identified no shortfalls.

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.

Management and staff adhere to open disclosure and communication is maintained with residents and relatives. Information about the Code and services is easily accessible to residents and families. 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.		Standards applicable to this service fully attained.

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 2019. Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around clients' needs.

Continuum of service delivery

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

The registered nurses are responsible for all aspects of service provision. 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.

Planned activities are appropriate to the residents assessed needs and abilities and residents advised satisfaction with the activities programme.

Medication policies reflect guidelines. There is an electronic medication management system at the facility. All staff who administer medications have current medication competencies. There is a three-monthly general practitioner review.

All food and baking are done on site. 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.		Standards applicable to this service fully attained.

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.

Restraint minimisation and safe practice

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

The 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

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.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control.

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy describes the management of the complaints process. There are complaint forms available. Information about complaints is provided on admission. A suggestions box is held at reception. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. A review of the complaints log/register evidences that four complaints had been made since the last audit. The service had four complaints made since the previous audit in 2017. 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. Complaints are linked to the quality and risk management system. Interviews with residents and relatives confirmed that issues are addressed promptly and that they feel comfortable to bring up any concerns.
Standard 1.1.9: Communication Service providers communicate effectively	FA	Relatives interviewed (one rest home and two dementia) confirmed they are notified following a change of health status of their family member. This was also confirmed in ten incident forms reviewed. Rest home 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

with consumers and provide an environment conducive to effective communication.		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 37 residents, (20 rest home and 17 dementia level care). On the day of the audit there were 35 residents in total, 20 rest home, and 15 dementia level residents. All permanent residents were under the Aged Residential Care (ARC) contract. The facility has two shared rooms in the dementia unit, these were occupied by single residents on the day of the audit. As per MOH letter dated 8 August 2017, these two rooms were verified as part of this audit as suitable to be used as double rooms. There is a policy in place which provides the registered nurse with the process of assessing residents' compatibility for sharing a room. There is a 'checklist for evaluating shared room placement' for staff to complete, and there is a consent form specific to shared rooms to be signed by both relatives/EPOA. 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 another 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 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system	FA	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 bi-monthly combined quality/management meetings. Resident meetings have been held regularly every three months. The owner/manager facilitates the quality programme and ensures the internal audit schedule is followed.

that reflects continuous quality improvement principles.		Corrective action plans are developed and signed off when service shortfalls are identified. 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 2018 resident/relative survey has been completed and evaluated. The survey evidences that residents and families are overall very satisfied or satisfied with the service. Improvements as a result of the survey included improving the presentation of the meals, and reviewing the menus to provide more colour. Activities hours have been extended, exercises have been introduced, and van outings increased. The laundry service has been improved to ensure resident clothes are ironed correctly, and encourage staff to renew clothing labels when needed to prevent lost clothing. A falls prevention group (resident relative and management input) has been implemented 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. Walking frames are removed from the dining rooms to provide a safer environment. An exercise programme has been implemented in both units.
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.	FA	The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Ten incidents reviewed (all incidents from February to April YTD) demonstrated follow-up by a registered nurse. Neurological observations were completed for all unwitnessed falls. The previous finding has been addressed. Accidents and incidents are analysed monthly with results discussed at the combined quality/staff meetings. NOK have been informed as requested on the instruction for informing relatives form completed on admission to the service. Relatives interviewed felt they are well informed in a timely manner of all accidents/incidents. The management team are aware of situations that require statutory reporting.
Standard 1.2.7: Human	FA	There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files sampled (one clinical lead/RN, one senior caregiver in the dementia unit, one

Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		recently employed caregiver, one nightshift caregiver, one diversional therapist) 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. The annual training plan has been implemented for 2018 and 2019 YTD. There were 16 caregivers that work in the dementia care unit; 13 had completed the required dementia standards and 3 were in progress of completing. The 3 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 identified 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 from 9.00 am to 5.00 pm during weekdays (one RN works Monday-Tuesday and the clinical lead works Wednesday- Friday). In the rest home (20 residents) there is one senior caregiver 7.00 am to 3.00 pm, one caregiver 7.00 am to 9.00 am. Afternoon shifts has one senior caregiver 3.00 pm to 11.00 pm and one caregiver 6.00 pm to 7.30 pm, and one senior caregiver on the night shift. In the dementia care unit (15 residents) there is one senior caregiver 7.00 am to 3.00 pm, and one caregiver 7.00 am to 1.30 pm. The afternoon shift has one senior caregiver 3.00 pm to 11.00 pm and one caregiver 4.30 pm to 8.00 pm and one senior caregiver on the night shift. Short shifts can be extended when required. Staff and residents interviewed, confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time.
Standard 1.3.12: Medicine	FA	Medication policies align with accepted guidelines. Ashlea Grove has recently implemented an electronic

Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		system. The RNs and senior caregivers responsible for the administration of medications have completed annual competencies and medication education. The administration of medications observed during the lunchtime medication round comply with the medication administration policies and procedures. The previous finding has been addressed. Medication reconciliation is completed on arrival by the RN. Any pharmacy errors are recorded and fed back to the supplying pharmacy. Standing orders were in use and are being transferred to the new electronic system, these 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. Signing charts were documented in the electronic system. The previous finding has been addressed. 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. 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. A food control plan is in place expiring 28 September 2019. 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 and reviewed by the GP and dietitian.
Standard 1.3.6: Service Delivery/Interventions Consumers receive	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. Continence products were available (sighted) and resident

adequate and appropriate services in order to meet their assessed needs and desired outcomes.		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 and evaluations were in place for two wounds, one chronic ulcer and one superficial moisture lesion. 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 monthly 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 share their time between the dementia care unit and the rest home. The programme is planned over a seven-day week. Rest home activities are held between 11.30 am to 2.30 pm, and dementia activities start at 2.30 pm to 4.30 pm. Caregivers hold activities in the dementia unit from 6.00 pm to 6.30 pm each evening. 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, baking (making a cheese ball for the happy hour), manicure and foot spa treatments, praise be sessions and van trips. Men's activities are tailored to each individual interest and capabilities at the time. 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 school, and to twice-weekly community eldercare group meetings. Residents were observed being encouraged and participating in activities on the days of audit. A sensory room is being developed in the dementia unit as a new initiative. 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	FA	In all files sampled the long-term care plans have been reviewed at least six monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Files reviewed demonstrated that short-term needs were documented on short-term care plans, which were regularly evaluated.

manner.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	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. There have been considerable refurbishments completed since the previous audit, including repainting of the exterior of the building. The dementia unit has been fully painted and carpet has been installed. New king single beds and furniture have been purchased throughout the facility. Hospital beds are available when required. The gardens have been upgraded, and the service is currently looking at re-carpeting the whole of the rest home area, and making further upgrades to the dementia outside area. There is a keypad lock system to entrance and exit doors in the dementia care unit. All maintenance records were reviewed and are clearly documented. The current building warrant of fitness expires on 12 July 2019. The hot water temperatures are monitored monthly. Review of the records reveals temperatures are maintained at required standards. The previous finding has been addressed. 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 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 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. Monthly data and graphs are displayed for staff, and discussed at monthly meetings and handovers as required. 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. The clinical lead is the restraint coordinator. Staff have been trained in restraint minimisation and the management of behaviours that challenge, last completed 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.

No data to display

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.

No data to display

End of the report.