

Ambridge Rose Cottage Limited - Ambridge Rose Cottage Limited

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 Q-Audit 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: Ambridge Rose Cottage Limited

Premises audited: Ambridge Rose Cottage Limited

Services audited: Dementia care

Dates of audit: Start date: 12 August 2019 End date: 13 August 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 24

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

Ambridge Rose Cottage provides a secure environment for up to 24 residents. The Cottage was purchased by new owner/directors in 2018 who commenced a full refurbishment of the facility.

This combined certification audit was conducted against the health and disability standards and the providers contract with the district health board. The audit included a full review of policies, procedures and quality related records, interviews with staff, management, family members and one general practitioner. Resident and staff files were also sampled.

The organisation has met all requirements and has been allocated a continuous improvement rating regarding quality activities.

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.
--	--	--

Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. The complaints process is accessible and meets consumer rights legislation.

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.
---	---	--

The owners/directors monitor organisational performance and set the strategic direction. The facility manager has the required skills and experience. The documented quality and risk management system is fully implemented, with improvements to service demonstrating improved outcomes for residents.

Human resource processes are in place and are monitored. All staff have the required qualifications and receive relevant on-going education. The appropriate number of staff, with the required skills, are on duty at all times.

Individual residents' records are maintained. Resident information is sufficiently documented to ensure safety and continuity. All records are secure.

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.
--	--	--

Residents are assessed prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Twenty-four-hour activity needs are identified in individual care plans. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan was in place. Nutritional snacks are available 24 hours.

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 facility is fit for purpose and provides safe indoor and outdoor areas. The grounds are secure. All areas and equipment are well maintained. A hazard management programme is implemented. The required emergency equipment and procedures are accessible. Bedrooms, bathrooms and communal areas provide residents with sufficient space. The indoor temperature is controlled.

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.
---	--	--

Ambridge Rose Cottage has processes in place for determining safe and appropriate restraint and enabler use. The facility is a secure unit, and on the day of audit there were no residents requiring the use of restraints or enablers. Staff interviewed demonstrated a good understanding of restraint and enabler use. Restraint is part of orientation and training is provided annually or as necessary.

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 prevention and control programme is, appropriate to the size and scope of the service. All staff receive the required training. Adequate resources and equipment are available. The number and type of diagnosed infections are monitored.

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	45	0	0	0	0	0
Criteria	1	92	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ambridge Rose Cottage has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training as verified in the training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) and the general practitioner makes a clinically based decision on resuscitation authorisation. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members interviewed were aware of the advocacy service, how to access this and their right to have support persons. The facility manager and staff provided examples of the involvement of advocacy services in relation to residents' care.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure complies with Right 10 of the Code. All new residents/family are given information regarding the complaints process on entry. The information provided includes the internal complaints process and the Ministry of Health complaints process for the residential sector. Family members interviewed confirmed receipt of the required information.</p> <p>There has been one complaint from a neighbour regarding the time the delivery truck comes to deliver food services in the morning. This was responded to and addressed by the CEO in a timely manner. Corrective actions were implemented and the complainant was satisfied with the outcome. Records of correspondence were sighted.</p> <p>Annual family surveys and six-week admission surveys provide opportunities for family to provide feedback regarding any compliments or concerns. It was reported that any day to day concerns are addressed by the facility manager with an open manner and frequent correspondence.</p> <p>There is a complaint register template, however this had not been used as there have been no complaints from residents or family. There have been no known complaints to external agencies.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information about the consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members interviewed were aware of consumers rights and confirmed that information was provided to them during the admission process.</p>

		The information pack outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. There are four shared bedrooms and consents were obtained from the EPOAs. Residents are supported to maintain their independence with the residents able to come and go within the building and around the secure grounds as they please. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The facility manager reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There are no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/whanau interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. Assessments and care plans document any cultural/spiritual needs. Special consideration to cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were no residents who identify as Maori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The facility manager stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Refer standard 1.2.3 regarding additional examples of good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff know how to access interpreter services if required. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation is governed by the two owners/directors. One of the owners/directors is the chief executive officer (CEO) and the other is the manager. The owners/directors have two other aged care facilities, with Ambridge Rose Cottage being their first venture into the provision of dementia services. Both owners/directors have had many years' experience in the aged care sector and are active in the industry. The organisation is a current member of the NZ Aged Care Association (NZACA). The owners/directors are accessible at all times and on site up to three times per week.</p> <p>The owners/directors set the strategic direction for the organisation. Business planning is conducted on an annual basis and records sampled confirmed that the CEO is monitoring achievement towards business and strategic goals. The owners/directors are also monitoring organisational performance. This includes financial reporting and the review of all outputs and outcomes through quarterly reports and management meetings. Management meetings include a</p>

		<p>review of service delivery including compliance requirements, health and safety, adverse events, infection prevention and control, quality outcomes and equipment/maintenance. The CEO also receives weekly emails, on a set template, from the facility managers of each of the sites. This email correspondence includes details regarding admissions, discharges, assessments, and the current health status of residents.</p> <p>The owners/directors are supported by the management team. This includes a quality manager and the chief operating officer (COO). These two staff members work across the three facilities. The COO has overall responsibility for human resources and maintenance requirements and the quality manager oversees the quality programme and provides some staff training.</p> <p>A new facility manager (FM) was appointed at Ambridge Rose Cottage in February 2019. The Ministry of Health and district health board (DHB) were informed. The FM's position description was sighted and included the required responsibilities and authorities. The FM is an enrolled nurse and has many years working in the aged care sector, with previous experience in dementia. The FM's curriculum vitae (CV) was sighted and confirmed experience and qualifications. The FM's training record confirmed that attendance at training exceeded the required number of hours annually.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The COO has the delegated authority to fulfil the role of the CEO during a temporary absence. Day to operations at the Cottage are the responsibility of the FM who had been working with the organisation in a consultancy role since October 2018, prior to the appointment of the FM. In the event the FM is temporarily absent, oversight of the Cottage is delegated to other members of the management team, with support from the registered nurse for clinical oversight.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented quality and risk management system. The required policies and procedures are documented and reviewed as required. Comments made by the auditor, prior to the audit, regarding policies and procedures had been acknowledged and addressed. There is evidence that policies and procedures are updated when required, with clinical policies and procedures reflecting current best practice. Policies and procedures are available to staff in hard copy, with electronic versions controlled by management to ensure ongoing integrity of the system. Obsolete documents are removed from circulation and a copy of archived documents is maintained. New or amended policies are introduced to staff during staff meetings and posted on the notice board in the staff room.</p> <p>A range of quality activities are implemented. These include quality data regarding internal audits,</p>

		<p>satisfaction surveys, resident outcomes, infection control surveillance and health and safety. The internal audit system is comprehensive and provides the organisation with ongoing confidence that systems are being maintained. In addition to routine compliance monitoring, the organisation also implements a variety of quality improvement initiatives which has resulted in the allocation of a continuous improvement rating.</p> <p>All quality related activities are discussed at staff and management meetings. Staff meetings are conducted every two months and staff attendance is encouraged. Minutes include discussions regarding any previous actions, feedback/complaints, the results of internal audits, health and safety, supply performance, the analysis of adverse events, infection prevention and control data, a review of restraints, clinical issues, upcoming training, quality and risk, fire safety and emergency procedures.</p> <p>Resident/family surveys are also routinely conducted. There is a six-week post admission satisfaction audit and annual satisfaction survey. These were sighted and confirmed general satisfaction with the services provide.</p> <p>Organisational risks are identified and monitored. The CEO completes a SWOT (strengths, weaknesses, opportunities and threats) analysis during the strategic and business planning process. There is also an organisational risk register. The register covers the scope of the organisation and includes a risk analysis regarding likelihood, consequence and the success of mitigating factors. The health and safety programme meets the requirements of current legislation.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an adverse event reporting system. Adverse events are documented on the adverse event form and forwarded to the FM. A range of adverse event records were sampled and confirmed that the appropriate emergency response, investigation and notifications were made. Corrective actions are developed where required. Refer standard 1.2.3 regarding the continual improvement rating with reduced adverse events following the implementation of quality improvement initiatives.</p> <p>All events are categorised and collated monthly. Any events that fall into the 'other' category are described. The monthly report is discussed in detail at the staff and management meetings. Records of staff meetings sampled confirmed that staff are encouraged to report all events, which are treated in an open and fair manner.</p> <p>There was one coroner's investigation in December 2018 following a sudden death. The resident has been at Ambridge Rose Cottage for one week and was in hospital at the time of death. The coroner's report concluded that the resident died of natural causes and no further investigation was required.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The COO is responsible for human resource processes and shares the recruitment process at the Cottage with the FM. All staff have a police check and professional qualifications are validated. This includes qualifications of the required dementia training for health care assistants, annual practicing certificates for the registered and enrolled nurse (FM) and certificates of all involved allied health providers.</p> <p>There is an orientation process. The orientation programme includes the essential components of service delivery. Orientation records were sighted in staff records sampled. All new staff are buddied by a senior staff member and are additional to the roster for up to three days. The new staff members orientation workbook is signed off by the FM, and the person who buddied them. All staff are employed on a 90-day trial, with records of the 90-day review sighted in staff records sampled.</p> <p>All staff are provided with ongoing training. The training plan for 2019 was sampled and confirmed that routine relevant training is provided. Staff are advised of scheduled routine training via the staff notice board and the organisation has recently commenced an online training programme. Individual staff training records are maintained and confirmed good attendance at training, with mandatory topics attended by all staff. The QM maintains a system to monitor staff attendance and ensures that staff are able to access and attend the training that is required. All staff have the required dementia training or are working towards it. Staff who administer medication have a documented competency which is repeated annually. Additional competencies include restraint, emergency procedures, manual handling and infection prevention and control.</p> <p>Staff performance appraisals are completed annually. Annual appraisals were sighted in all staff records sampled. There is a staff satisfaction process. Staff interviewed reported that they are satisfied with the support they get from management and were pleased that improvements had been made to both the facility and service delivery since the owner/directors took ownership in 2018.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented staffing rational. The rational meets the requirements of the district health board and maintains safe and timely service delivery. The FM is responsible for developing the rosters. Rosters were sampled and confirmed that the required number of staff, with the required skills and experience were on duty every shift. This included at least one staff member on each shift with a current first aid certificate. Rosters sampled also confirmed that replacement staff were rostered in the event of an unplanned staff absence.</p> <p>The FM is onsite Monday to Friday and there is a registered nurse who is employed for 40 hours</p>

		per week. There are two health care assistants on each shift. The activity coordinator is also onsite during the day, as is the cook. Staff and residents' family members interviewed were satisfied with the number of staff on each shift.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The majority of resident records are held electronically. All staff have an individual password to the resident records data base. The visiting GP's and allied health providers also have access to the system which maintains the integration of resident records. The front page of the residents electronic file includes links to all other related data, photo identification and risks. Daily entries are made into the electronic progress notes which automatically assigns the time of entry and the name and designation of the writer.</p> <p>Some resident records are maintained in hard copy. This includes the admission agreement, consent agreements and the current care plan. All hard copies are kept securely in the office. Hard copy archived records are stored safely and securely on site. There is a system for retrieving both hard copy and electronically stored resident records.</p> <p>A specimen signature list is maintained to ensure the traceability of all hard copy records which require a signature.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Ambridge Rose Cottage's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe medication management system was observed. Indications for use are noted on 'as required' medications, allergies are clearly indicated, and photos are current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. All medicines are reviewed every three months and as required by the GP.</p> <p>A health care assistant was observed administering medications safely and correctly. The medication and associated documentation are in place. Medication reconciliation is conducted by the RN or FM when a resident is transferred back to service. The RN or FM checks medicines against the prescription. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. The service does not keep any vaccines. There were no residents self-administering medications. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted, and this was confirmed on previous entries. On the day of the audit, there were no residents prescribed controlled medication.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is an approved food plan for the service. Meal services are prepared on site and served in the allocated dining room. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer meal in place.</p> <p>The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night on. The family members interviewed acknowledged satisfaction with the food service.</p> <p>All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>The FM reported that all consumers who are declined entry are recorded and when entry is</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Residents have their level of care identified through needs assessment by NASC agency. Initial assessments were completed within the required time frame on admission while resident care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. Additional assessments were completed according to the need e.g. behavioural, nutritional, continence, skin and pressure assessments. The nursing staff utilise standardised risk assessment tools on admission. In interviews conducted family/whanau expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Acute care plans were used for short-term needs. Family/whanau interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, district nurses, dietitian and GP.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Interventions are adequate to address identified needs in the care plans. The individual behaviour management plans specified prevention-based strategies for minimising episodes of challenging behaviours and described how the residents' behaviour was best managed over a 24-hour period. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. The GP reported that medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Health care assistants confirmed that care was provided as outlined in the care plan. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' activities interest form and health passports are completed within two weeks of admission in consultation with the family. The activities are conducted by the activities coordinator with oversight from a qualified diversional therapist (DT) from another sister facility. The activities coordinator and the FM formulate activities on a daily basis depending on the weather conditions, suggestions from family/whanau and events of the day. The activities are varied and appropriate for people living with dementia and are offered from Monday to Sunday.</p> <p>Twenty-four-hour activity interventions are imbedded into the long-term care plans and these were sighted in all files sampled. Residents' electronic files have a documented activity plan that reflects their preferred activities of choice and are evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is documented on each shift by care staff in the electronic progress notes. The registered nurse and FM read progress notes daily and document as necessary. All noted changes by the health care assistants are reported to the RN in a timely manner.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by either the RN or FM in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Acute care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or</p>	<p>FA</p>	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP, RN or FM sends a referral to seek specialist service provider assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurse, FM or</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and procedures for the management of waste and hazardous substances. Domestic waste is placed in waste management bins and removed from the facility twice per week. Cleaning and laundry chemicals are safety stored. There are sharps containers and adequate supplies of personal protective equipment are provided and readily accessible throughout the facility. All staff receive education regarding the management of waste and hazardous substances. Hazardous substances are identified on the hazard register. There have been no reported adverse events regarding the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility was purpose built in the 1980's. There is a current building of warrant of fitness. Since taking ownership the owners commenced refurbishment of the entire facility. This has included painting, replacing furniture, fittings, floorings and equipment. Resident bedrooms are being redecorated as they become vacant. External areas have been improved to provide safe and interesting areas for the residents to spend time outdoors. Residents can safely access all external areas with the exception of the laundry.</p> <p>Maintenance is completed in an ongoing manner. A maintenance person is employed across the three facilities. There is evidence that any requests for day to day maintenance are attended to in a timely manner. An inspection of the facility confirmed that all maintenance concerns were being addressed. There is a hazard management programme. All hazards are identified and monitored accordingly, with any concerns reported to management and discussed at staff meetings. Routine environmental audits are completed monthly which helps to ensure that the environment remains safe and fit for purpose. Electrical testing and tagging are completed as required. Medical devices, such as scales, blood pressure monitors and thermometers have been calibrated. There is a pest control programme in place. All resident areas are of sufficient size to accommodate any equipment or aids.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities.</p>	<p>FA</p>	<p>There are six communal toilets and two shower rooms. Toilets are identifiable (refer to standard 1.2.3 regarding the continuous improvement rating). The doors to the shower rooms are painted the same colour as the corridor wall which helps prevent residents from entering the shower rooms on their own. A shower list is maintained to ensure all residents are showered routinely. All</p>

<p>Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>residents have a handbasin in their bedroom. Hot water temperatures are routinely monitored.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There are twenty bedrooms. This includes four shared bedrooms with two beds each. Family members interviewed confirmed that they had consented to the residents sharing a bedroom, with these residents sharing a bedroom prior to the current owner's purchase. Privacy of these residents is maintained with all dressing and personal cares completed in the shower rooms. All beds and linen were purchased new by the current owners. All bedrooms have a basin and a wardrobe. Residents rooms are personalised. Rooms are of sufficient size to accommodate equipment if this was required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are two communal areas. One is a double lounge which can be converted into two smaller lounges if needed. There is also a smaller family/whanau room which provides a quieter area for residents and visitors. Activities take place in a variety of areas around the facility, including the main lounge. There are no restrictions regarding visiting hours, with family interviewed confirming that they are made welcome at any time and gain entry by pushing the external entry button.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There is a designated laundry which is located externally to the facility. The laundry is not accessible to residents and panelling has been installed to ensure privacy of resident's personal items when hanging on the clothes line. The owner has installed a closed-circuit chemical system which includes the required safety information. There are three washing machines and a recently purchased industrial dryer. The laundry has clearly identified areas for clean and dirty linen. A new cleaning trolley has also been purchased When not in use this is securely stored in the laundry. There is a secure cupboard in the laundry for storing any cleaning products.</p> <p>Policies and procedures regarding all cleaning and laundry services are documented and readily available to staff. These provide clear directions regarding the required tasks, safety and infection control requirements. Chemical safety training has been provided in the in-service training programme.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and satisfaction surveys. These demonstrate compliance with internal requirements and general satisfaction from family members.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>All staff receive training on emergency management and evacuation procedures. There is an approved fire evacuation plan. Fire systems and equipment are checked annually during the building warrant of fitness inspection. Evacuation drills are completed every six months.</p> <p>The building has emergency lighting in the event of a power failure. Alternative sources for cooking and heating are accessible. There is a well-stocked civil defence kit and a sufficient amount of emergency water.</p> <p>The facility provides a secure environment. Entry to the facility is by call bell only. Doors into residents' rooms are closed during the day and individually identified. The external areas have sensor lighting. Staff ensure the facility is well secured each evening. There are working call bells in each of the resident rooms.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There is thermostatically controlled heating throughout the facility and temperatures can be monitored. The facility has plenty of natural light and ventilation. Each bedroom has an external window of normal proportions. There are no residents or staff that smoke on the premises.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>There is a documented infection prevention and control programme. The programme is reviewed annually. The review includes a review of the last year's annual infection control data, plus training, internal audits and policies and procedures. The review is completed by the facility manager and reported in the quality programme.</p> <p>The FM oversees the infection prevention and control programme with support from the RN and the quality manager. The role of the coordinator is defined.</p> <p>Exposure to infection is prevented in a number of ways. The organisation provides relevant training, there are adequate supplies of PPE and hand sanitisers, hand washing audits are completed, the required policies and procedures are documented, and staff are advised to not attend work if they are unwell. Flu infections are offered to all staff and residents.</p>
<p>Standard 3.2: Implementing the</p>	<p>FA</p>	<p>The infection control team includes the RN, quality manager and FM who disseminate information to staff. The FM has had previous external training in infection prevention and control conducts the</p>

<p>infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>in-service training programme. Specialist support can be accessed through the district health board, the medical laboratory of the GP.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The required policies and procedures are documented. These are developed by an external consultant and reflect legislation and current good practice. All policies and procedures are readily available to staff. Infection prevention and control, food handling and cleaning/laundry policies and procedure were reviewed by the lead auditor prior to the audit.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff training on infection prevention and control are routinely provided during orientation and annual in-service education. Inservice education is conducted by members of the infection control team and was last provided in April 2019. All infection prevention and control training include standard precautions and hand washing. Records of staff education are maintained.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance programme is defined and appropriate to the size and scope of the service. All diagnosed infections are collated every two months for review and analysis. This includes the infection category and antibiotic use. Infection control surveillance data confirmed that the Cottage has had a minimal number of infections, with one infection reported over the winter months.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Ambridge Rose Cottage has a commitment to provide quality services for residents in a safe and secure environment and work to minimise the use of restraint. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. Restraint is part of orientation and training is provided annually or as necessary. Restraint competencies are</p>

		<p>completed. The management team, including restraint coordinator, meets every two months to review restraint, enabler, training and policy. Approved restraint and enablers include bed sides and lap belts, and there were no residents using restraint on the days of the audit. Staff interviewed understood the difference between a restraint and an enabler. All staff are trained in the management of challenging behaviour.</p>
--	--	--

Specific results for criterion where corrective actions are required

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

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

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

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	<p>There is an internal audit schedule. This includes routine and proactive audits. For example, a medication audit was brought forward on the schedule following an adverse event. A range of internal audits were sampled. The results of these audits are analysed and there is evidence that corrective actions are developed, implemented and monitored as required. A number of quality improvements have also been implemented. These improvements have been documented using a quality improvement framework. For example:</p> <p>Health and Disability Commission Health Passports were introduced to the admission process in February 2019. Residents family members were asked to complete the health passport prior to admission and this process has been trialed on the last three admissions. Information collected and feedback from family demonstrated an improved admission process for both the resident and family member, with reports of the resident settling better during this time. Family also stated that the process of completing the health passport provided them with an opportunity to reflect on the life of the resident and felt more resolved regarding the need for their family member to enter a secure dementia facility. The process was reviewed in June 2019 and is now being implemented routinely into the admission process.</p> <p>Door labels have been attached to each resident’s bedroom door. These include the residents preferred name and a picture of something that is meaningful to them. This has resulted in a reduction</p>	A range of quality initiatives have been developed, implemented and reviewed, resulting in improved outcomes for residents.

		<p>of residents entering other resident rooms with less agitation on a daily basis.</p> <p>All toilet doors have been painted red with a picture of a toilet on the door resulting in residents being better able to identify the toilets. Five residents were monitored over a four-week period. These five residents were fully incontinent using high absorbency incontinent products. These residents are now actively and independently using the toilet more often and are using lower absorbency products.</p>	
--	--	---	--

End of the report.