

Phantom 2021 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 Ngā paerewa Health and disability services standard (NZS8134:2021).

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

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking [here](#).

The specifics of this audit included:

Legal entity: Phantom 2021 Limited

Premises audited: Ashlea Grove Rest Home

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

Dates of audit: Start date: 18 July 2024 End date: 19 July 2024

Proposed changes to current services (if any): The previous audit findings relating to the partial provisional medication management and environmental changes are no longer applicable and the proposed changes will not be implemented as planned.

Total beds occupied across all premises included in the audit on the first day of the audit: 34

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 sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections applicable to this service partially attained and of low risk

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

General overview of the audit

Ashlea Grove rest home is located in Milton, South Otago. The service is certified to provide rest home and dementia level care for up to 37 residents. There were 34 residents on the days of the audit.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Services Standard 2021 and the services contract with Health New Zealand Te Whatu Ora – Southern. The audit process included a review of quality systems, the review of residents and staff files, observations, and interviews with residents, family/whānau, staff, management, and a nurse practitioner.

Ashlea Grove rest home has set several quality goals which link to the organisation’s business plan. The managing directors have extensive experience in the aged care sector and are supported by an assistant manager and the clinical lead (registered nurse). Feedback from residents and families was very positive about the care and the services provided.

The previous partial attainment related to care plan evaluations continue to require addressing.

This surveillance audit identified no additional areas of improvement.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.



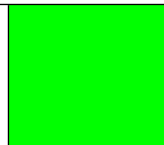
Subsections applicable to this service fully attained.

The service provides an environment that supports residents' rights, and culturally safe care. Details relating to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) is included in the information packs given to new or potential residents and family/whānau. There is a Māori health plan in place. There were Māori residents at the time of the audit. Cultural assessments inform the cultural care plan.

Residents and family/whānau interviewed confirmed that they are treated with dignity and respect. There was no evidence of abuse, neglect, or discrimination. There is an established system for the management of complaints that meets guidelines established by the Health and Disability Commissioner.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.



Subsections applicable to this service fully attained.

The 2024 business plan includes specific and measurable goals that are regularly reviewed. The service has implemented quality and risk management systems that include quality improvement initiatives. Internal audits and the collation of clinical indicator data were documented as taking place, with corrective actions as indicated. Hazards are identified with appropriate interventions implemented.

A recruitment and orientation procedure is established. Caregivers are buddied with more experienced staff during their orientation. There is a staffing and rostering policy. A staff education/training programme is being implemented.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs. Interventions were appropriate and evaluated in the care plans reviewed.

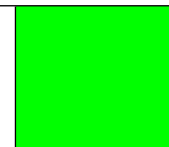
The organisation uses an electronic medicine management system for e-prescribing and administration of medications. The general practitioner is responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes. Nutritional snacks are available for residents 24 hours.

Residents are referred or transferred to other health services as required.

Te aro ki te tangata me te taiao haumaruru | Person-centred and safe environment

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.



Subsections applicable to this service fully attained.

There is a current building warrant of fitness. There is a planned and reactive maintenance programme in place.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.



Subsections applicable to this service fully attained.

An infection control programme is documented for the service. Staff have attended education around infection control.

Surveillance of health care-associated infections is undertaken, and results are shared with all staff. Follow-up action is taken as and when required. There has been one outbreak since the previous audit in July 2022.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.

Subsections applicable to this service fully attained.

The service is committed to maintaining a restraint-free service. There were no residents using restraints at the time of the audit. This is supported by the governing body and policies and procedures. Staff interviewed demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions to prevent the use of restraint.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	17	0	0	1	0	0
Criteria	0	50	0	0	1	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā paerewa Health and disability services standard

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

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>There is a documented commitment to recognising and celebrating tāngata whenua in a meaningful way through partnerships, educational programmes, and employment opportunities. The Māori health plan references local Māori health care providers and provides recognition of Māori values and beliefs. The plan acknowledges Te Tiriti o Waitangi as a founding document for New Zealand. There are residents who identify as Māori. A Māori family member (interviewed) confirmed that mana motuhake is recognised. At the time of the audit, there were Māori staff. Staff have completed training around cultural safety and Te Tiriti o Waitangi.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples</p>	FA	<p>Ashlea Grove rest home has a Pacific health plan and cultural policy that encompasses the needs of Pasifika and upholds the principles of Pacific people by acknowledging respectful relationships and embracing cultural and spiritual beliefs and providing high quality healthcare. At the time of the audit there were no Pasifika residents. There were Pasifika staff.</p>

for improved health outcomes.		
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. The clinical lead (interviewed) demonstrated how it is also provided in welcome packs in the language most appropriate for the resident to ensure they are fully informed of their rights. Three residents interviewed (rest home) and three family/whānau (one hospital and two dementia) reported that all staff respected their rights, and that they were supported to know and understand their rights. Care plans reviewed were resident centred and evidenced input into their care and choice/independence. Staff have completed training on the Code.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	FA	<p>An abuse and neglect policy is being implemented. Ashlea Grove rest home policies prevent any form of discrimination, coercion, harassment, or any other exploitation. Comprehensive house rules are discussed and signed by staff during their induction to the service. The house rules and/or the employee handbook code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the house rules and the employee handbook as part of the employment process.</p> <p>Staff complete education on orientation and biennially as per the training plan on how to identify abuse and neglect. Staff are educated on how to value the older person, showing them respect and dignity. All residents and families/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. The service implements a process to manage residents' comfort funds, such as sundry expenses.</p> <p>Professional boundaries are defined in job descriptions. Interviews with registered nurses and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation.</p> <p>Interviews with six staff (three caregivers, one clinical lead, one maintenance and one cook), three managers (one assistant manager and two managing directors), residents (three rest home) and family/ whānau (one hospital level care and two dementia) and documentation reviewed, confirmed that the</p>

		staff are very caring, supportive, and respectful.
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>	FA	<p>There are policies documented around informed consent. Staff and management have a good understanding of the process to ensure informed consent for all residents (including Māori, who may wish to involve whānau for collective decision making). Five resident files were reviewed and written general consents sighted for outings, photographs, release of medical information, medication management and medical cares were included and signed as part of the admission process. Specific consent forms had been signed by residents or their activated enduring power of attorney (EPOA) for procedures, such as vaccines and other clinical procedures. Interviews with family whānau and residents confirmed their choices regarding decisions and their wellbeing is respected.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	FA	<p>The complaints procedure is provided to residents and families/whānau during the resident's entry to the service. Access to complaints forms is located at the entrance and in the admission pack or on request from staff. Residents or relatives making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. The Code of Health and Disability Services Consumers' Rights and complaints process is visible, and available in te reo Māori, and English.</p> <p>A complaints register is maintained which includes all complaints, dates and actions taken. There have been three internal complaints received since last audit. There have been no complaints received from external agencies.</p> <p>Review of documentation and an interview with the assistant manager, demonstrated that complaints are managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with residents and family/ whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. Information about the support resources for Māori</p>

		<p>is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The clinical lead acknowledged their understanding that for Māori, there is a preference for face-to-face communication and to include whānau participation. Staff interviewed confirmed they are informed of complaints (and any subsequent corrective actions) in staff meetings.</p>
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>FA</p>	<p>Ashlea Grove Rest Home, located in Milton, South Otago, is certified for up to 37 beds: twenty rest home level and 17 dementia level beds. At the time of audit, there were 34, residents in the facility: 17 rest home residents including one resident with an approved hospital dispensation by Health New Zealand (4 June 2024), two residents on long term chronic health contracts (LTS- CHC) and 17 dementia level care residents. All remaining residents were on the age-related residential care agreement (ARRC). The facility has two shared rooms in the dementia unit, with both rooms currently being shared by two residents. There are written agreements on file from the families of all residents involved in this arrangement. There is a privacy curtain in place and individual lighting and call bells.</p> <p>The managing directors (husband/wife team) have managed the facility since 2015 and fully owned the facility since December 2021. Both managers have extensive experience in elderly care management within New Zealand and have maintained at least eight hours annually of professional development activities related to managing a rest home. One managing director, and an assistant manager, are responsible for the general day to day non-clinical oversight of the facility. The other managing director is the operation's manager and is responsible for health and safety, human resources, and maintenance. He is supported by a full-time maintenance officer. They are supported by a clinical lead (RN) and a part-time registered nurse (RN) with experience in aged care. Both have a current annual practising certificate.</p> <p>The managing directors are the governing body for Phantom Eldercare trading as Ashlea Grove Rest Home. The assistant manager, with the support of the managing directors, has overall responsibility for the development and implementation of the quality and risk programme, including the implementation and close out of corrective actions. Ashlea Grove has a business plan for 2022-2025. This includes the mission</p>

		<p>statement that sets out the vision and values of the service. The plan identifies strengths, weaknesses, threats, and opportunities, and includes goals and aspirations. The plan is reviewed at least annually. The business plan reflects a commitment to collaborate with Māori, aligns with the Ministry of Health strategies, and addresses barriers to equitable service delivery.</p> <p>The managing director consults with mana whenua (via staff members, residents and their family/whānau) in business planning, organisational policy, and service development to improve outcomes and achieve equity for Māori. The service has Māori staff who provided input into the use of te reo Māori signage.</p> <p>The findings in relation to the partial provisional audit (October 2022) related to medication management and environmental changes. While these have been signed out as closed, the managing directors have decided they will not proceed with the proposed changes.</p> <p>Residents receiving services and whānau are supported to participate in the planning, implementation, monitoring, and evaluation of service delivery through surveys, meetings, and an open-door management policy.</p>
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	<p>FA</p>	<p>Ashlea Grove has an implemented quality and risk management programme, developed by an external contractor. The quality system includes performance monitoring; internal audits; resident family satisfaction; staff retention; and the collection, collation, and comparison of clinical indicator data. Three monthly staff meetings provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received; staffing; and education. Internal audits, meetings, and collation of data were verified as taking place, with corrective actions documented where indicated to address service improvements, with evidence of progress and sign off when achieved. Quality goals and progress towards attainment are discussed at meetings. Quality data and trends are added to meeting minutes and available for staff to access in the nurses' stations. Corrective actions are discussed at staff meetings to ensure any outstanding matters are addressed with sign off when completed.</p> <p>The assistant manager submits a weekly report to the managing director ensuring governance remain fully informed of all key performance indicators,</p>

	<p>HR, occupancy, complaints, internal audits results, corrective action progress and general business. The assistant manager, the managers from the three other services owned by Phantom and the managing directors meet six weekly providing collegial support and an opportunity to discuss benchmarking trends and share improvement ideas.</p> <p>Resident, family/whānau satisfaction surveys are completed annually. The June 2023 and most recent July 2024 resident, family/ whānau satisfaction surveys have been collated and analysed and indicate that residents, family/ whānau have reported high levels of satisfaction with the service provided. Results of the current satisfaction survey are an agenda item at the next staff meeting. Management advise resident and families will be notified via the next newsletter and resident meeting. Comments identifying opportunity for improvement have been identified and corrective actions documented.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. Policies are regularly reviewed and have been updated to align with Ngā Paerewa NZS 8134:2021. A document control system is in place. New policies or changes to policy are communicated to staff. A health and safety system is in place. Hazard identification forms are completed, and an up-to-date hazard register was reviewed (sighted). Manufacturer safety datasheets are up to date. Staff are kept informed on health and safety issues in handovers and meetings. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form.</p> <p>Hard copy accident/incident forms are completed for each incident/accident, and immediate action is documented with any follow-up action(s) required, evidenced in the accident/incident records reviewed. Each incident involving a resident reflected a clinical assessment and follow up by a registered nurse. Opportunities to minimise future risks were identified where possible through a corrective action plan and discussions at staff meetings. Incident and accident data is collated monthly, analysed for trending and benchmarked against others Phantom facilities. Results are discussed at the meetings.</p> <p>Discussions with the assistant manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one Section 31 notification completed to notify HealthCERT of an absconding incident. There was one Covid-19 outbreak since the</p>
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		previous audit, which was appropriately notified.
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	FA	<p>There is a staffing policy that describes rostering. The roster provides sufficient and appropriate coverage for the effective delivery of care and support. The registered nurses, activities staff, and a selection of caregivers hold current first aid certificates. There is a first aid trained staff member on duty 24/7. Interviews with staff confirmed that their workload is manageable, and that management is very supportive. Staff and residents are informed when there are changes to staffing levels, evidenced in staff interviews.</p> <p>The managing directors, assistant manager and clinical lead are available Monday to Friday. Clinical on-call is provided by the clinical lead. The assistant manager and/or managing director is available 24/7 for any non-clinical concerns.</p> <p>There is a biennial education and training schedule being implemented that includes mandatory training across 2023 and 2024. A record of completion is maintained on staff file records and hard copy training register. The education and training schedule lists compulsory training, which includes Māori health, tikanga, and Te Tiriti O Waitangi. Cultural awareness training is part of orientation and provided biennially to all staff. Training to care for dementia residents includes dementia care which incorporates challenging behaviours and de-escalation. External training opportunities for care staff include training through Health New Zealand - Southern.</p> <p>Competencies and questionnaires are completed by staff, which are linked to the education and training programme. Staff completed competency assessments and/or questionnaires as part of their orientation related to cultural competency, fire safety, cultural safety including bias and discrimination, workplace bullying, stigma and racism, infection control, hand hygiene, manual handling, and medication management. These are repeated annually as evidenced in the staff files reviewed. All care staff who administer medications are required to complete medication competencies annually. Management have recently introduced a staff led training booklet, which staff complete in conjunction with an external electronic training programme aligned with the biennial training programme. The new programme has been embraced by the staff with evidence of staff completion within required timeframes. A record of completion is maintained</p>

		<p>in the training register.</p> <p>The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Of the 15 caregivers and the diversional therapist, nine have completed level 3 and above. All the caregivers work in the dementia unit with nine caregivers having completed the required dementia unit standards; seven caregivers are currently enrolled and all seven have been employed less than 18-months.</p> <p>Additional RN competencies cover medication administration, interRAI assessment and wound management. There are two registered nurses (including the clinical lead) with one of the two registered nurses being interRAI trained.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation, and staff training and development. Staff files are stored securely in the assistant manager's office. Five staff files reviewed evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation programmes specific to their roles. All staff signed a code of conduct document at time of employment commencement.</p> <p>There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, and additional roles (e.g., restraint coordinator, infection control coordinator) to be achieved in each position. All staff sign their job description during their onboarding to the service.</p> <p>A register of practising certificates is maintained for all health professionals. The appraisal policy is implemented. All staff who had been employed for over one year have an annual appraisal completed.</p> <p>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they</p>	<p>PA Moderate</p>	<p>Five resident files were reviewed: three rest home (including one resident with hospital level care dispensation and one on a LTC-CHC contract) and two dementia level of care. All other residents were under the age-related</p>

<p>know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>residential care (ARRC) agreement. The registered nurses (RN) are responsible for all residents' assessments, care planning and evaluation of care. Care plans are based on data collected during the initial nursing assessments, which include but not limited to values, beliefs, sexuality, skin assessment and pressure injury risk, level of personal ability, social history, pain, depression, behaviour, mental perception, elimination, mobility and falls risk, sleep, orientation, activity level, dietary needs, and information from pre-entry assessments completed by the Needs Assessment Service Coordination (NASC) or other referral agencies.</p> <p>Initial assessments and long-term care plans were completed within the required timeframes for residents, detailing needs, and preferences. The individualised long-term care plans (LTCPs) are developed with information gathered during the initial assessments and the interRAI assessment. All interRAI assessments and LTCPs sampled had been completed within three weeks of the residents' admission to the facility. Documented interventions and early warning signs meet the residents' assessed needs; with interventions to provide guidance to care staff in the delivery of care. The activity assessments include a cultural assessment which gathers information about cultural needs, values, and beliefs. Information from these assessments is used to develop the resident's individual activity care plan.</p> <p>Short-term care plans are developed for acute problems, for example infections, wounds, and weight loss. Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the registered nurse. Long-term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and when there is a change in the resident's condition. Evaluations are documented by registered nurses however did not always include the degree of achievement towards meeting desired goals and outcomes. This is a repeat finding from the previous audit. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms.</p> <p>There was evidence of family/whānau involvement in care planning and documented ongoing communication of health status updates. Family/whānau interviews and resident records evidenced that family/whānau are informed where there is a change in health status. The service has policies and procedures in place to support all residents to access services and information. The service supports and advocates for</p>
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	<p>residents with disabilities to access relevant services.</p> <p>Residents in the dementia unit have behaviour assessments and behaviour plans with associated risks and supports needed and includes strategies for managing/diversion of behaviours. The 24-hour behaviour care plan includes close to normal routine that shows a 24-hour reflection of resident's usual pattern and behaviour management strategies to assist caregivers in management of the resident behaviours.</p> <p>The initial medical assessment is undertaken by the general practitioner (GP) within the required timeframe following admission. Residents have ongoing reviews by the GP within required timeframes and when their health status changes. There are weekly GP visits and as required. Medical documentation and records reviewed were current. The GP interviewed stated that there was good communication with the service and that they were informed of concerns in a timely manner. The contracted GP is also available on call after hours for the facility. A physiotherapist is available as required through referral. There is access to a continence specialist as required. A podiatrist visits regularly and a dietitian, speech language therapist, hospice, psychiatrist, wound care nurse specialist and medical specialists are available as required through Health New Zealand Southern.</p> <p>An adequate supply of wound care products was available at the facility. A review of the wound care plans evidenced that most wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated, and a wound nurse specialist was consulted. At the time of the audit there were 13 active wounds from eight residents, including skin tears and a chronic ulcer.</p> <p>The progress notes are recorded and maintained in the integrated records. Monthly observations such as weight and blood pressure were completed and are up to date. Neurological observations are always recorded following un-witnessed falls or where there is suspected injury to the head. A range of monitoring charts are available for the care staff to utilise. These include (but not limited to) monthly blood pressure, fluid balance, weight, bowel records and repositioning chart. Review of records confirmed that these monitoring charts were completed as indicated. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Staff receive a comprehensive verbal handover at the beginning of their shift</p>
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		<p>which caregivers confirmed on interview was informative and included changes in care needs, appointments and all updates in resident conditions.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies available for safe medicine management that meet legislative requirements. Staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided.</p> <p>All medication charts and signing sheets are electronic. Staff were observed to be safely administering medications. The registered nurses and caregivers interviewed could describe their role regarding medication administration. The service uses blister packs for all regular medications and bottles for 'as required' medicines. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. The effectiveness of 'as required' medications is recorded in the electronic medication system and in progress notes.</p> <p>Medications were appropriately stored in the medication trolley and the medication cupboard. The medication fridge and medication room temperatures are monitored daily. All eyedrops and creams have been dated on opening. Controlled drugs are stored appropriately, and weekly stock check has been completed regularly by medication competent staff. Medication incidents were completed in the event of a drug error and corrective actions were acted upon.</p> <p>Ten electronic medication charts were reviewed. The medication charts reviewed identified that the general practitioner had reviewed all resident medication charts three-monthly, and each medication chart has photo identification and allergy status identified. There was one resident self-administering medications. Approval was supported by the GP and hospice staff and medications are appropriately stored in a locked safe in the resident room in accordance with policy. There are no standing orders in use.</p> <p>Previous partial attainments related to the partial provisional medication room and trolley changes identified at the previous audit are no longer applicable. The proposed changes have been cancelled.</p>

<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people’s nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	FA	<p>Residents’ nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify residents’ personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. A spreadsheet ensures residents receive their special diets and food preferences. Copies of individual dietary preferences were available in the kitchen folder. A food control plan is in place and expires in February 2025. Nutritional snacks are available for residents 24 hours.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	FA	<p>A standard transfer notification form is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families/whānau were involved in all transfers to and from the service and there was sufficient evidence in the residents’ records to confirm this. Records sampled evidenced that the transfer and discharge planning included risk mitigation and current residents’ needs. The discharge plan sampled confirmed that, where required, a referral to other allied health providers to ensure the safety of the resident was completed.</p>
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises</p>	FA	<p>The buildings, plant, and equipment are fit for purpose at Ashlea Grove rest home and comply with legislation relevant to the health and disability services being provided. The environment is inclusive of people’s cultures and supports cultural practices.</p> <p>The current building warrant of fitness expires 12 July 2025. There is an annual maintenance plan that includes electrical testing and tagging, equipment checks, call bell checks, and monthly testing of hot water temperatures. Calibration of medical equipment is one month overdue because of delays related to the contracted provider. Confirmation of a completion date for the beginning of August has been sighted in an email.</p>

<p>people's sense of belonging, independence, interaction, and function.</p>		<p>Previous partial attainments related to the partial provisional environmental changes identified at the previous audit are no longer applicable. The proposed changes have been cancelled.</p>
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>FA</p>	<p>The infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. Policies and procedures are provided by an external consultant with input from infection control specialists and reviewed by the management team. Infection control is included in the internal audit schedule. Any corrective actions identified have been implemented and signed off as resolved. The infection control programme is reviewed and reported on annually.</p> <p>Infection prevention and control is part of staff orientation and included in the biennial training plan. Staff education includes (but is not limited to): standard precautions; isolation procedures; hand washing competencies; and donning and doffing of personal protective equipment (PPE). The clinical lead is the infection control coordinator. The service receives additional support from expertise at Health New Zealand - Southern.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection programme as described in the infection prevention control policy. Monthly infection data is collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the paper-based infection register and surveillance of all infections (including organisms) is collated onto a monthly infection summary. Reports include antibiotic use.</p> <p>This data is monitored and analysed for trends, monthly and annually. Ashlea Grove rest home incorporates ethnicity data into surveillance methods and data captured around infections. Infection control surveillance results are discussed at staff meetings. Meeting minutes and data are available for staff. Action plans are completed for any infection rates of concern. Internal infection control audits are completed, with corrective actions for areas of improvement.</p> <p>Ashlea Grove rest home receives regular notifications and alerts from Health New Zealand- Southern for any community concerns. There has been one</p>

		Covid-19 outbreak (December 2023) reported since the previous audit in July 2022. This was well documented, managed, and reported to Public Health.
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	FA	<p>Maintaining a restraint-free environment is the aim of the service. Policies and procedures meet the requirements of the standards. An interview with the restraint coordinator (clinical lead) described Ashlea Grove rest home's commitment to restraint minimisation. This is supported by the governing body and policies and procedures. On the days of audit there was no restraint in use.</p> <p>Restraint is included as part of the orientation for staff and staff attend training in behaviours that challenge and de-escalation techniques. Alternatives to restraint, behaviours that challenge, and residents who are a high falls risk are discussed at staff meetings and at six monthly falls prevention meetings. There is a falls prevention group evidencing ongoing reduction in falls. Any use of restraint and how it is being monitored and analysed would be reported at these meetings.</p> <p>A comprehensive suite of policies including assessment, approval, monitoring, and quality review process is documented for potential use of restraint. At all times when restraint is considered, the facility will work in partnership with Māori, to promote and ensure services are mana enhancing, and the cultural advisor will be consulted as required.</p>

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 3.2.5</p> <p>Planned review of a person’s care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person’s agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(d) Identify changes to the person’s care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented;</p> <p>(e) Ensure that, where progress is different from expected, the service provider in</p>	<p>PA Moderate</p>	<p>Evaluations of care and support are completed in a timely manner and reflective of the care the resident requires; however, not all evaluations reviewed were reflective of resident goals.</p>	<p>Three of five care plans reviewed did not document progression towards meeting goals.</p>	<p>Ensure evaluations document progression towards meeting goals.</p> <p>60 days</p>

collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.				
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Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this audit.

No data to display

End of the report.