

Milton Adams Limited - Cromwell House Hospital

Introduction

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

The audit has been conducted by Health Audit (NZ) 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:	Milton Adams Limited
Premises audited:	Cromwell House Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 March 2017 End date: 31 March 2017
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:	43

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

Cromwell House Hospital provides rest home, hospital and secure dementia level care for up to 50 residents. The service is privately operated and managed by a facility manager and clinical leaders. Residents and families spoke positively about the care provided.

This certification audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

There is one area for improvement identified at this audit related to the assessment process. There were no other systemic issues identified.

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.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services 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 confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

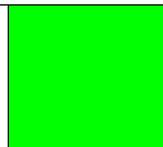
Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided is regular and effective. An experienced and suitably qualified person manages the service. The facility manager is supported by clinical leaders who are registered nurses.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There are documented admission processes that require potential residents to be assessed at rest home, dementia or hospital level of care.

The nursing staff are responsible for the development of the care plans. Care plans are evaluated, reviewed and amended when clinically indicated by a change in the resident's status or at least every six months. Assessments are developed and evaluated. A 24-hour dementia diversion care plan was sighted in all care plans in the dementia unit.

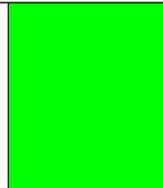
There are planned activities that are meaningful to the residents, develop and maintain residents' strengths skills, resources and interests. In interviews, residents and families expressed satisfaction with the activities programme.

A medication management system complies with legislation and best practice guidelines for aged care. Medications are administered by nursing staff with current medication competencies. There were no residents self-administering medications.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. The kitchen was observed to be clean, tidy and meets food safety standards.

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.

Cromwell House Hospital consists of two buildings, one for the hospital level of care and one that has the secure dementia unit and the rest home level of care residents. Services are provided in a safe, secure environment that is appropriate to needs of the residents. There are appropriate amenities to meet residents' needs and to facilitate independence.

Residents, visitors and staff are protected from harm because of exposure to waste, infectious or hazardous substances generated during service delivery. Laundry services are contracted to an off-site provider. There are adequate toilets, showers, and bathing facilities.

Documentation identifies that all processes are maintained to meet the requirements of the building warrant of fitness. Planned and reactive maintenance is documented. There is generalised wear and tear appropriate to the age of the buildings. Systems are in place for essential, emergency and security services, including a disaster and emergency management plan.

All residents have access to a fully fenced, secure outdoor area with shaded areas. The dementia unit is separated from the rest home/hospital areas. The design of the dementia unit and gardens provides safe wandering areas for residents with cognitive impairment.

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.
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There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education.

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.
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and service providers. The infection control coordinator is responsible for the surveillance programme, coordinating education, and training of staff. Documentation evidences that relevant infection control education is provided as part of staff orientation and as part of the on-going educational programme. Infection data is collated monthly, analysed and reported during staff meetings. Surveillance for infection is carried out as specified in the infection control programme. The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported in a timely manner.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	1	0	0	0
Criteria	0	92	0	1	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>The organisation has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy with residents. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records sampled.</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 evidenced informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to give consent is defined and documented, as relevant, in the residents' records. Staff were observed to gain consent for day to day care.</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>During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service. Posters and brochures related to the advocacy service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</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 organisation 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 dealings 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 policy and associated forms/flow charts meet the requirements of Right 10 of the Code. The policy defines the actions/responses to take related to major and minor complaints. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint if they wished to.</p> <p>The complaints register sampled showed that complaints have been received over the past three year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. There are no complaints recorded to date in 2017. Action plans show any required follow up and improvements have been made where possible. Facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service as part of the admission information provided and in discussion with staff. The information for the residents is also revisited during visits from the advocacy service. The Code is displayed in both buildings, together with information on advocacy services, how to make a complaint and feedback forms.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have private rooms.</p> <p>Care plans sampled included documentation relating to the residents' abilities with strategies to maximise independence. The 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>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during sampling of orientation and ongoing education records.</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>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate the cultural values and beliefs that they choose. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on Tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents' files recorded their individual cultural needs. Staff demonstrated knowledge of the individual needs of the resident.</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>	<p>FA</p>	<p>Residents and families reported that they were consulted on their or their relatives' individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans sampled. The resident satisfaction survey confirmed that individual needs are being met.</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>Residents and 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 relating to professional boundaries, expected behaviours and the code of conduct. All registered nurses have records of completion of the required training on professional boundaries. 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.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The organisation encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psych geriatrician and mental health services for older persons. The ongoing staff education programme covers the specific needs of the residents at the rest home, hospital and dementia level of care. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the dementia service and memory garden are based on dementia friendly design principles.</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>Residents and family members stated they are kept informed about any changes to their/their relative's status, are 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 that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required with staff able to provide interpretation as and when needed with the use of communication aids and family members. There are appropriate processes and communication strategies recorded in care plans for residents with non-verbal communication and cognitive impairment.</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>Cromwell House Hospital provides rest home, hospital and secure dementia level of care for up to 50 residents. There are two buildings, one that contains the hospital and one that has the secure dementia unit and the rest home wing. At the time of audit there were 21 hospital level of care residents (including one resident under the age of 65), three rest home level of care residents and 19 residents living in the dementia unit.</p> <p>The service is a privately-owned business with three directors. The directors have the governance responsibilities. The facility manager has informal and formal communications and feedback to at least one of the directors at least weekly.</p> <p>The business plan records the scope, vision, mission statement, philosophy of the</p>

		<p>organisation with the organisational objectives documented. The plan is reviewed annually, with the specific plans, aims and ambition for 2017 recorded. The ongoing review of the goals and objectives is monitored through monthly staff meetings.</p> <p>The service is managed by a facility manager and two clinical leaders (RNs). The facility manager has responsibility for the overall organisational management, with the support of the two clinical leaders responsible for the clinical aspects of service delivery. The facility manager has managed the service for over eight years. The facility manager is a member of an aged care association and attends over eight hours a year of professional development related to management of an aged care service. The facility manager receives weekly updates from the aged care association and has monthly updates related to employment and legislative changes from an employment association.</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>	FA	<p>During temporary absences of the facility manager, either of the two clinical leaders takes on the facility management role. For longer term absence over three weeks, a specialised manager is contracted.</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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, resident/family feedback, monitoring of outcomes, clinical incidents including infections and restraint minimisation. Meeting minutes sampled confirmed regular review and analysis of quality data and outcomes of any quality audits/activities. Staff reported their involvement in quality and risk management activities through internal audits and attendance at staff meetings.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey recorded overall high satisfaction with the care and service provided. There was some feedback on the laundry, activities, knowledge of complaints and rights, which have all been actioned.</p> <p>Policies sampled cover all necessary aspects of the service and contractual requirements, including reference to pressure injury prevention and management. The policies are developed by an aged care consultant and personalised to reflect the nature of the service.</p>

		<p>Policies are current and are referenced to best practice and legislation.</p> <p>All policies are version controlled, with staff only having access to the most recent version. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described and the risk register documents the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff through the monthly staff meetings.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made since the previous audit.</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>	FA	<p>Human resource management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records sampled have documentation of completed orientation and an initial education workbook that covers the aged care contractual requirements. In-service education is planned on a biannual basis, including mandatory training requirements. Staff working in the dementia care area have either completed or are enrolled in the required education. The diversional therapist has completed education and qualifications related to dementia care.</p> <p>There are two trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessment (refer to 1.3.3.3 for the implementation of interRAI).</p> <p>Performance reviews are conducted annually. Six of the seven files reviewed had the</p>

		required performance review, with one staff member having a performance review over 12 months prior. This is not reflective of a systemic issue, with the facility manager having a schedule for performance reviews implemented for 2017.
<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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery. The staffing numbers are based on safe staffing guidelines and the acuity of the residents. When there is an increased level of dependencies or needs, staffing is increased to match these increased needs. When a resident is admitted to the service, particularly the dementia unit, an extra staff member is allocated to provide one to one support to the new resident. The rosters sampled evidenced staffing numbers more than the minimum contractual requirements. The staffing numbers and skill mix meets the needs of the current residents and the layout of the facility for the residents at rest home, hospital and dementia level of care.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and sampling of rosters confirmed adequate nursing, care staff, diversional and housekeeping cover has been provided, with staff replaced in any unplanned absence. The kitchen and laundry services are provided by external service providers.</p> <p>There is at least one staff member on duty that has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information (refer to 1.3.3.3 for ensuring the updating of interRAI). Records were legible with the name and designation of the person making the entry identifiable. Electronic records are password protected.</p> <p>Archived records are held securely on site in locked cupboards and the attic storage space. The records in storage are retrievable. Residents' files are held for the required period before being destroyed by a secure document removal provider. No personal or private resident information was on public display during the audit.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Cromwell House Hospital welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the families of choice where appropriate and local communities and referral agencies. Admission requirements are conducted within the required time frames and are signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Families 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>	<p>FA</p>	<p>The standard transfer form notification from the district health board 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 resident's 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>There is a documented policy for the management of the medication system. All medication files sampled confirmed that they are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are documented, identification photos are present and three monthly reviews are completed. Medication charts are legibly written. The RN was observed administering medication correctly. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service.</p> <p>The service uses pharmacy pre-packed packs that are checked by the RNs on delivery. The controlled drug register is current and correct. Weekly and six monthly stock takes are conducted and all medications are stored appropriately. There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management system complies with legislation, protocols and guidelines.</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</p>	<p>FA</p>	<p>The meal service is outsourced, prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents at the service. A nutritional profile is developed on</p>

<p>is a component of service delivery.</p>		<p>admission which identifies dietary requirements, likes and dislikes. Supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p> <p>The food service audit and satisfaction survey conducted in July 2017, indicated that residents/family are happy with the meals provided and any other adjustment will be made accordingly.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The clinical leader who is a registered nurse reported that whenever an applicant is declined entry families are informed of the reason for this and other options or alternative services are offered. The enquirer is referred to the referral agency to ensure that they 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>The initial assessments are completed within the required time frames on admission while care plans are completed within three weeks of resident's admission. Assessments and care plans are detailed and include input from the residents, families and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews, the families expressed satisfaction with the support provided. Refer to 1.3.3.3 for improvement related to the use of the interRAI.</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>Life style and nursing care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate life style and nursing care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The residents and families interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</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>The documented interventions in short term care plans and life style and nursing care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family's members interviewed reported satisfaction with the care and support they are receiving</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 meaningful to the residents' needs and abilities at Cromwell House Hospital. The activities programme covers physical, social, recreational, spiritual, intellectual emotional and cultural needs of the residents. The diversional therapist reported that they ascertain the resident's response and interest during activities and modify activities accordingly and oversees activities when they are conducted by the care partners. Activities are provided for the all residents rest home, hospital and dementia level of care.</p> <p>The activities are modified as per capability and cognitive abilities of the residents. The diversional therapist develops an activity planner which is posted on the notice boards and residents informed by word of mouth. Residents' files have a documented activity plan that reflects their preferred activities of choice. Over the course of the audit residents were observed engaging in a variety of activities. The residents and families reported general satisfaction with the level and variety of activities provided. There is a 24-hour dementia activities plan for dementia residents.</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>Residents' life style and nursing care plans and activity plans are evaluated at least six monthly and updated when there are any changes. Families, residents (where appropriate) and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed, dated and closed out when the acute problem has resolved. The required evaluations were sighted in resident records sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	<p>FA</p>	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>by the nursing staff or GP.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this appropriately.</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>Both buildings have a current building warrant of fitness publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. The staff knew the processes they should follow if any repairs or maintenance is required.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The secure dementia unit is separated from the rest home and hospital areas. The layout and external areas of the dementia unit are designed for the safe mobility of residents with cognitive impairment. There is a lift to access the upper level in the hospital building.</p> <p>Residents and families confirmed they are satisfied with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout both buildings. This includes a mix of shared ensuites and communal facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. The facilities are appropriately identified using a mix of picture signage, different coloured doors and written signage.</p>

assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are currently single accommodation. There are two hospital rooms that have the potential to be shared rooms. Where rooms are, shared approval has been sought. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are separated from each other and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. The secure dementia unit is separated from the rest home/hospital areas. Residents and families reported satisfaction with the communal areas.</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>	FA	<p>Laundry is undertaken off site by a contracted provider. The care partners demonstrated a sound knowledge of the laundry processes, storage, the dirty/clean flow and handling of soiled linen processes that work in conjunction with the contracted laundry provider. Residents and families reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There are designated cleaning teams and care partners who assist in the cleaning duties. The staff have received appropriate training, as confirmed in interview of cleaning staff and in training records. Chemicals are stored in a lockable cupboard and in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through a monthly report from the external chemical supplier and the internal audit programme.</p> <p>It was noted that there was a urine smell in the three-bedded rest home area. The carpets were cleaned by an external provider in 2017, strategies are in place for residents with incontinence. The carpet cleaning is part of the regular cleaning schedule. The residents in this area did not express concerns with the smell.</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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or another emergency.</p> <p>There is an approved evacuation scheme. A trial evacuation takes place six-monthly with a copy sent to the fire service, the orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies are available for use in the event of a civil defence emergency, including food, water, blankets and mobile phones. Food and water storage is located around the complex for emergency use. Supplies available meet civil defence guidelines. There is emergency lighting, which is inspected monthly as part of the fire/building warrant of fitness checks by an external provider.</p> <p>Call bells alert staff to residents requiring assistance. The staff have pagers and duress alarms to call for assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There are security cameras in the communal areas that assist in monitoring resident's mobility and the falls management programme.</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>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Several rooms in the hospital building have doors that open onto outside gardens or small patio areas. Heating is provided through a mix of air-conditioning/heat pumps and central gas heating in residents' rooms in the communal areas. Residents and families confirmed the buildings are maintained at a comfortable temperature.</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>Cromwell House Hospital provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical leader is the infection control coordinator (ICC) and has access to external specialist advice from the GPs' and district health board, and infection control specialists when required. The infection control programme at Cromwell House Hospital allows for a systematic, coordinated and continuous approach.</p>

		<p>The infection control programme is reviewed annually and is incorporated into the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview conducted with the ICC indicated that all infections are monitored through a surveillance system in accordance with the infection control programme. There are processes in place to isolate infectious residents when required.</p> <p>A documented job description for the ICC including role and responsibilities is in place. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated adequate human, physical, and information resources to implement the infection control programme. Infection control reports are discussed at the management and monthly staff meetings, or as when necessary. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</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>	FA	<p>Cromwell House Hospital has documented policies and procedures in place and reflect current best practice. Staff were observed to be following the infection control standards that comply with relevant legislation and current good practice. Staff demonstrated knowledge on the requirements of standard precautions and can locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service</p>	FA	<p>The ICC is a registered nurse and annual infection control education is provided to staff and is also included in the orientation process. Training sessions are documented and attendance records completed. The (ICC) has access to external specialist advice from the GPs', DHB and infection control specialists when required. In interviews conducted, staff affirmed an</p>

providers, support staff, and consumers.		understanding of how to implement infection prevention and control activities during their practice.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Minutes of meetings and education records were sighted. An external consultancy firm has provided tools to enable monthly analysis of infections comparing with other health care providers. The GP is informed within the required time frame to prescribe antibiotics if any resident has an infection.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	Cromwell House Hospital aims to minimise the use of restraint. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed were aware of the difference between a restraint and an enabler. The service currently has no residents using restraints nor enablers.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Each stage of service provision assessment, evaluation and review, using the interRAI were not provided within time frames. The sample size of timeframes of interRAI assessments was increased to sixteen.</p> <p>All files sampled identified that initial care plans and life style and nursing care plans are completed within the required time frames. The long-term care plans were completed within three weeks of admission. The long-term care plans are reviewed every six months or when there is any change in condition of a resident. Three monthly reviews are conducted by the general practitioner (GP) if residents are stable or as when required.</p> <p>Short term care plans are developed for short term problems or in the event of any change with detailed interventions to guide treatment in place and for staff to follow. Resolution dates are documented and</p>	Sixteen interRAI assessments were not reviewed and evaluated within the required time frame that safely meet the needs of the resident.	<p>Ensure interRAI assessments are evaluated and reviewed within the required time frames.</p> <p>90 days</p>

		care plans are closed out.		
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display

End of the report.