

# Rosebank Residential Limited

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Rosebank Residential Limited
<b>Premises audited:</b>	Rosebank Home and Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 6 May 2015      End date: 7 May 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	88

# Executive summary of the audit

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## 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
Yellow	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
Red	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

Rosebank rest home and hospital is a privately owned aged care facility. The service is governed by a board which meets monthly. Rosebank home and hospital provides care to up to 99 rest home and hospital level residents. Residents and families interviewed were very complimentary of care and support provided.

This certification audit was conducted against the relevant health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

Improvements are required in relation to management of verbal complaints, integration of quality data, consent and resuscitation status documentation, completion of education, reporting pressure areas, completion of neurological observations and wound, pain and mobility assessments, ensuring long term care plans are current and reflect all needs through complete assessments and interventions, and medication management.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The staff at Rosebank home and hospital ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. A complaints register is maintained for formal written complaints.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Rosebank home and hospital has a quality and risk management system in place. The service reports data to the relevant meetings. Annual surveys are completed. Health and safety policies, systems and processes are implemented to manage risk. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents

## 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 medium or high risk and/or unattained and of low risk.</p>
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Residents and families receive information on services provided at Rosebank rest home and hospital. The registered nurses are responsible for each stage of service provision. The initial and long term care plans and evaluations in files sampled were completed within the required timeframes. Residents and families interviewed confirm they participate in the care planning process. There is an improvement required around care plans and interventions to reflect the resident current health status and the use of assessment tools. Residents retain their own general practitioner. Residents are reviewed by their general practitioner at least three monthly.

The activity programme is varied and appropriate to the level of abilities of the residents. Community links are maintained. Entertainment and outings are provided.

Staff responsible for the administration of medications have an annual competency completed and attend medication education. Medication charts evidence three monthly reviews. There are improvements required around the prescribing of medications and self-medication documentation.

All food is prepared and cooked on site. There is dietitian input into the menu. Individual food preferences and dietary requirements are met. Alternative choices are offered for dislikes.

## 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.

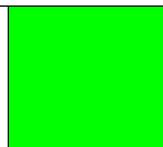


Standards applicable to this service fully attained.

There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building has a current warrant of fitness. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised with access to shared ensuites or communal facilities.

## 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.

There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were two residents requiring enablers and no residents requiring restraint. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation

## 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation, but has not been undertaken in the last two years as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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)
<b>Standards</b>	0	41	0	4	5	0	0
<b>Criteria</b>	0	91	0	5	5	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Discussions with staff confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (six rest home and one hospital) and five relatives (hospital) were interviewed and confirmed the services being provided are in line with the Code.</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>	PA Low	<p>The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Review of resident files identified that general consents were signed as part of the admission agreement. Three resuscitation forms had been signed by the EPOAs. There were copies of enduring power of attorney held in 10 resident files sampled (five rest home and five hospital).</p> <p>Discussions with caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.</p>

		D13.1 there were ten signed admission agreements sighted. D3.1.d Discussion with families identified that the service actively involves them in decisions that affect their relative's lives
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register has been maintained for formal written complaints. One complaint was logged each year 2013-2015. Systems and processes have been in place to ensure that any complaint received is managed and resolved appropriately. Verbal and emailed concerns are not logged in the complaints register or managed as per policy. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the

		resident. Residents and relatives interviewed identified they are well-informed about the code of rights. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available at reception.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment.</p> <p>Church services are held at least once a week in their onsite chapel and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has a Maori health plan and an individual's values and beliefs policy which includes cultural safety and awareness.</p> <p>Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There were no residents at Rosebank home and hospital who identified as Maori. The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</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>The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training (link # 1.2.7.5). The quality/health and safety co-ordinator and a registered nurse are responsible for coordinating the internal audit programme (link # 1.2.3.6). A variety of staff meetings and residents meetings are conducted.</p> <p>Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the management team. Care staff complete complete competencies relevant to their practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly and the facility manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>Rosebank home and hospital is privately owned and governed by a</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>board. The service provides care for up to 99 residents at hospital (geriatric and medical) and rest home level care. This includes ten swing beds that are available for hospital or rest home level. On the day of the audit, there were 88 residents in total (50 residents at rest home level and 38 residents at hospital level).</p> <p>The service has been managed by an experienced facility manager who has been in the role for over eight years. The facility manager reports monthly to the board on a variety of management issues. The current strategic plan and quality and risk management plans have been implemented. The facility manager receives support from a clinical services manager, education co-ordinator, quality/ health and safety/ infection control co-ordinator, registered nurses and care staff. Building and refurbishment work is planned to enlarge, refurbish and add ensembles to 16 rooms in the rest home wing.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical services manager provides cover during a temporary absence of the facility manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality manual and the business, quality, risk and management planning procedure describe the Rosebank home and hospital's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is discussed and listed in the quality improvement meeting, and the various facility meetings. However, meeting minutes included insufficient detail to provide an understanding for those that did not attend the meeting. Staff are expected to read and sign minutes if they did not attend. For small meetings (eg nurses ,CQI ,restraint) all participants are emailed a copy plus one hard copy is stored in a meeting minutes folder. For staff meeting minutes, one copy is on the notice board and then they are stored as a hard copy in the meeting minutes folder.</p> <p>Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings are held. Data is collected on complaints, accidents, incidents, infection</p>

		<p>control and restraint use. This data is presented meetings but does not include detail of trends, improvements undertaken or areas needing improvement.</p> <p>The internal audit schedule for 2014 has been completed but is not integrated, the internal audits are undertaken through two schedules (health and safety/clinical) co-ordinated by two different staff and not managed together. Areas of non-compliance identified at audits have been actioned for improvement but no evidence is documented on progress or resolution.</p> <p>The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly.</p> <p>Falls prevention strategies are implemented for individual residents. Residents' are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>Incident and accident data is collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for April and May 2015 were reviewed. Reports and corresponding resident files reviewed evidence that not all appropriate clinical care has been provided following an incident; neurological observations were incomplete (link 1.3.6.1). The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. When clinical files and wounds were reviewed there was no evidence of accident/incident forms being completed to report five pressure areas.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications and experience. A copy of practising certificates are kept. Nine staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 20 years.</p> <p>The service has an orientation programme that provides new staff with relevant information for safe work practice. An education co-ordinator was appointed six months ago and a full review of the orientation and education programme was undertaken. A more comprehensive orientation programme is in place and was evidenced in files of recently appointed staff. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff.</p> <p>The in-service calendar has been reviewed and expanded with additional education sessions provided to ensure compulsory and relevant education is provided annually moving forward. The education sessions in the last two years have not included abuse and neglect, advocacy, continence, infection control or management of behaviours that challenge.</p> <p>Of 47 care staff 31 have completed either the national certificate in care of the elderly or have completed or commenced an aged care education programme. The management team and registered nurses attend external training including conferences, seminars and education sessions with the local DHB.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Rosebank home and hospital has a four weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one registered nurse on duty at all times. The full time facility manager is also a registered nurse. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift. All registered nurses have been trained in first aid and CPR.</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>The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents have a needs assessment completed prior to entry that identifies the level of care required. The manager/registered nurse (RN) and clinical nurse manager/RN screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>Residents and relatives stated that they received sufficient information on admission. The service has an information pack, which includes advocacy and health and disability information.</p> <p>D13.3: the admission agreement reviewed aligns with a) -k) of the ARC contract.</p> <p>D 13.3 k: The admission agreement includes information about when a resident may be required to leave the facility.</p> <p>D14.1: Exclusions from the service are included in the admission agreement.</p> <p>D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is an exit discharge and transfer policy that describes guidelines for death, discharge, transfer, documentation and follow up. This directs staff to the appropriate documentation. All relevant information is documented and communicated to the receiving health provider or service. Follow up occurs to check that the resident is settled or, in the case of death, communication with the family is made</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>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. There is an improvement required around safe medication storage. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. One self-medicating resident has a current competency assessment, however three monthly reviews were not evident. Twenty medication charts were sampled. All medication charts sampled had photo identification and allergy status identified. Shortfalls have been identified around medication management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Rosebank are prepared and cooked on site. There is a four weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered in hot boxes to the hospital dining area. A bain marie is also used for the serving of meals. The cook is employed from 7.30am to 5.30pm and prepares all meals. She is supported by kitchen assistants with hours staggered across the day until 7.30pm. The cook interviewed is aware of resident dietary needs and notified of any changes. Resident likes and dislikes are accommodated. Cultural and religious food preferences are met. Specialised utensils and crockery are available for use to promote resident independence with meals.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents interviewed state alternative choices are offered for dislikes and expressed satisfaction with the meals.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are taken on the midday meal. Cleaning schedules are maintained.</p> <p>Chemicals are stored safely. Staff were observed to be wearing correct personal protective clothing.</p> <p>All food services staff have completed training in food safety and</p>

		hygiene and chemical safety.
<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>	FA	The reason for declining service entry to residents should this occur is communicated to the resident or family/ whanau and they are referred to the original referral agent for further information.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	The initial support plan is developed with information from the initial assessment, medical and discharge information. The resident/relatives are involved in the development of the initial assessment. Risk assessment tools are used to identify the required needs and interventions required to meet resident goals. Risk assessments were not all completed on resident files reviewed.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Care plans reviewed demonstrated service integration and included input from allied health practitioners. Interventions were not sufficiently documented to support the needs of all residents.</p> <p>D16.3k: Short term problem plans were in use for changes in health status such as altered behaviours, wound, falls and infections.</p> <p>D16.3f: There was documented evidence of resident/family/whanau involvement in the care planning process. Residents/relatives interviewed confirmed they participate in the care planning process.</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>	PA Moderate	<p>When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The caregiving staff stated they are kept informed on resident changes through handovers and progress notes.</p> <p>Dressing supplies are available and treatment rooms were well stocked for use. Documentation shortfalls have been identified around wound assessments and wound management.</p> <p>Continence products are available and specialist continence advice is</p>

		<p>available as needed.</p> <p>A number of shortfalls have been identified around monitoring, practice and documentation.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>There is a qualified diversional therapist (DT) and activity assistant employed to coordinate and implement activities for the rest home and hospital residents Monday to Saturday. The programme is integrated and on three days of the week there are two options of activities for residents to attend.</p> <p>The programme offers variety and interest with entertainment and outings. Residents were able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. Community links are maintained with groups such as churches, pre-schools, kapa haka groups, RSA and inter-home bowls and get-togethers. One on one time is spent with residents who are unable or choose not to participate in group activities. The three monthly resident meeting provides residents an opportunity to feed back on the activity programme. The activity team also make daily contact with residents.</p> <p>Activity assessments were completed on admission in the resident files sampled. Activity plans and care plans were reviewed at the same time. The DT maintains activity progress notes in the integrated files.</p> <p>The DT attends regional meetings and on-site education. The DT and activity assistant have current first aid certificates.</p> <p>There are 35 volunteers that assist the activity team in providing individual and group activities. Some volunteers have been long serving with up to 20 years with the service. All volunteers are taken through an induction that includes for example; fire drill, safe resident handling and reporting of accidents/incidents. Volunteers are involved in piano playing, one on one resident visits and chats, hand massages, resident shopping and assisting with resident outings. The volunteers do regular canteen trolley rounds to the residents and responsible for the re-stocking of supplies. The DT holds two monthly meetings with the volunteers ensuring they are kept informed on facility and activity matters. Volunteers are greatly appreciated for their contribution to the</p>

		service and residents. They are acknowledged formally at the annual Christmas event. Volunteers were observed interacting with residents on the day of audit
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Initial care plans reviewed were evaluated within three weeks of admission. Long term care plans reviewed have been evaluated by the registered nurses (link 1.3.5.2). The residents GP examines the residents and reviews the medications at least three monthly. Short term care plans reviewed for short term needs were evaluated within a timely manner.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</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>	FA	<p>Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>D16.4c; The service provided evidence of re-assessments for higher level of care (rest home to hospital).</p> <p>D 20.1 discussions with the clinical nurse manager and registered nurses identified that the service has access to GPs, ambulance/ emergency services, allied health, dietitians, physiotherapy, continence and wound specialists.</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>	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets were readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. A chemical spills kit was available. All staff have attended chemical safety training.

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires on 1 July 2015. The service employs a maintenance person four days a week, who is available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through a maintenance request system. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded two monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access, ramps and rails to all communal areas and outdoor areas. There is outdoor seating and shade.</p> <p>ARC D15.3: The caregivers and registered nurses interviewed stated they have all the equipment required to provide the level of care documented in the care plans including (but not limited to); electric beds, shower beds, toilet chairs, wheelchairs and hoists (standing and lifting), chair scales and hoist weigh scales.</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 assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. All bedrooms have hand basins. There are some bedrooms with a shared ensuite. There are adequate numbers of communal toilets and showers for each wing. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All resident rooms are single. There is adequate space for residents to safely manoeuvre around the room with the use of mobility aids. Hospital rooms including the 10 dual purpose rooms in the rest home wing have adequate space for the use of and transferring equipment including hoists. Residents and families are encouraged to personalize their rooms as viewed on the day of audit.</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 within the facility include lounge and dining areas in rest home and hospital units. The rest home dining and lounge area can be opened up to provide a larger space for special events and entertainment. There are smaller lounges at the end of each wing. The communal areas are easily accessible for residents. There are private family rooms and an on-site chapel. Activities were seen to occur in various locations throughout the facility.</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>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry operates until 7pm daily. The laundry has a dirty to clean work flow with an entry and exit door. There are dedicated laundry and housekeeping staff seven days a week. Cleaning trolleys were kept in designated locked cupboards. Residents and family interviewed report satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</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>	FA	<p>The service has a fire and emergency procedures manual. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. A call bell light over each door alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources were available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks have been conducted each night by staff.</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>	FA	<p>Visual inspection evidences that the residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature with underfloor heating.</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>	FA	<p>Rosebank home and hospital has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and is linked into the incident reporting system. The health and safety co-ordinator (registered nurse) is the designated infection control nurse with support from the facility manager, clinical service manager and the infection control team. The IC team meets and reviews infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</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>There are adequate resources to implement the infection control programme at Rosebank home and hospital. The infection control (IC) nurse has maintained her practice by attending infection control updates. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse with support from the education co-ordinator. All infection control training has been documented and a record of attendance has been maintained, infection control education has not been completed within the last two years (link # 1.2.7.5). Information is provided to residents and visitors that are</p>

		appropriate to their needs and this was documented in medical records.
<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	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly and annually at facility and organisational level. An outbreak in 2014 was appropriately managed, with notification to the relevant authority</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by a restraint coordinator who is the clinical service manager. There were two residents utilising enablers (one lap belt for use in a wheelchair and one bedrail) and no residents using restraint. The use of enablers is voluntary, requested by the resident. A full restraint assessment is completed prior to implementing the enablers. There is evidence of the residents consenting to the enabler. In addition, there is evidence of monitoring of residents who were using enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint coordinator is the clinical service manager (registered nurse). Assessment and approval process for a restraint intervention included the restraint coordinator, registered nurse, resident/or representative and medical practitioner</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, a registered nurse, the resident and/or their</p>

		representative and a medical practitioner are involved in the assessment and consent process. In the two files reviewed (enablers), assessments and consents were fully completed. Consent for the use of restraint was completed with family/whanau involvement and a specific consent for enabler / restraint form was used to document approval.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval processes. There is an assessment form/process that was completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. Three files reviewed had a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. The service has a restraint and enablers register which is up dated each month
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations have been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings. There are six monthly restraint meetings held. Monitoring is documented every 30 minutes while the enabler is in use.



## 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)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	Advance directives were sighted in the resident files sampled. Advance directives have been made for serious illness, hospitalisation and resuscitation status.	The enduring power of attorney (EPOA) has signed the resuscitation status for two hospital and one rest home resident.	Ensure the resident (assessed as competent) only signs the resuscitation order.  90 days
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	There is a complaints register that has one logged written complaint each year with documented evidence of follow up, investigation and communication as per the facility policy.	Verbal and emailed concerns have not been logged in the complaints register and managed as with formal written complaints.	Log all complaints in the complaints register and manage as per policy.  90 days
Criterion 1.2.3.6 Quality improvement data	PA Low	The quality manual and the business, quality, risk and management planning	Quality data is not fully integrated and documented through the quality system. Meeting minutes do not provide the detail	Ensure quality data is recorded, and communicated to all relevant people. Ensure meeting minutes

are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		procedure describe the Rosebank home and hospital's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility.	around feedback on internal audits, corrective actions, accidents and incidents, infections, complaints or quality improvements and are not readily available. Areas of non-compliance identified at audits have been actioned for improvement but no evidence is documented on progress or resolution.	document quality data, corrective actions and quality improvements and be readily available to staff.  90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incident and accident data is collected and reported at monthly meetings (link 1.2.3.6).	Five pressure areas (heel, hip and three on buttocks) have not been reported on an accident /incident form. Follow up on accidents and incidents is not documented or sign off.	Ensure accident/incident forms are completed for all adverse events, including pressure injuries. Ensure I&A's evidence follow up and sign off.  30 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	An education co-ordinator plans and manages the education programme to ensure staff have appropriate training that includes compulsory topics.	The education sessions in the last two years have not included abuse and neglect, advocacy, continence, infection control or management of behaviours that challenge.	Ensure all compulsory education topics are completed by all staff within the scheduled timeframes.  90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation	PA Moderate	The medication charts reviewed identified that the GP had seen and reviewed the resident medications at least three monthly.	(i) Five of twenty medication charts did not have each medication dated. One of 20 charts did not have each medication signed. (ii) Eight of twenty medication charts did not have indications for use of as required medications. (iii) The key to the second rest home medication room is not kept on the person responsible for	i) and ii) Ensure medication charts meets legislative requirements. iii) Ensure access to the medication room is restricted to the person responsible for medications.  30 days

in order to comply with legislation, protocols, and guidelines.			administering medications.	
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	There is one resident-self medicating insulin. Documentation was not up to date	There is no record of three monthly reviews of the self-medication competency for one resident self-medicated insulin since August 2014. There is no record of insulin administration for three days on the current signing sheet	<p>Ensure self-medication competencies are completed at least three monthly. Ensure records of insulin administration are maintained</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Moderate	Risk assessment tools are available for use as applicable. Risk assessment tools reviewed were evaluated six monthly or earlier as required. All resident files sampled had a pressure area and falls risk completed and reviewed six monthly.	(i) There were no pain assessments for four hospital residents and three rest home residents with identified pain and on pain relief. (ii) There was no mobility assessment for one hospital resident (medium risk) and one rest home resident (high risk) as identified on the care plan. (iii) Mobility assessments have not been reviewed for two hospital residents. (iv) There was no continence assessment for one rest home resident with known continence problems.	<p>Ensure risk assessment tools are completed and reviewed where applicable for pain, mobility, continence and other areas of identified risk.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	The service is currently developing a more comprehensive care plan to align with the InterRAI assessments. Interventions were not sufficiently documented to support the needs of all residents.	Care plans reviewed did not include interventions to describe the required supports for the following; (i) pain management for three rest home and four hospital residents (link hospital tracer), (ii) the management of an a) ileostomy (link rest home tracer); b) indwelling catheter (hospital resident), and c) syringe driver site (hospital resident), (iii) diagnosed medical	<p>Ensure care plans describe the interventions needed to support the resident assessed needs.</p> <p>60 days</p>

			<p>condition as per discharge letter. (iv) There were no documented interventions for three residents with weight loss (two hospital and one rest home). (v) There were no pressure area interventions for the five hospital residents with pressure areas. The grade and size of pressure areas were not identified (link 1.2.4).</p>	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Short term problem plans document the management of short term needs. Wounds (including five pressure areas) have been evaluated as per the dressing schedule. Caregivers interviewed were familiar with the care required.</p>	<p>The following shortfalls have been identified around practice and documentation; (i) There was no recorded weight on admission or the following two consecutive months for one hospital resident; (ii) There was no monitoring of the effectiveness of pain relief for residents receiving as required analgesia. (iii) There were no documented de-escalation techniques/alternative strategies/activities for two residents with challenging/altered behaviours as per the behaviour chart and progress notes. (iv) There were no wound assessments for 12 of 17 wounds (includes five pressure areas); (v) Neurological observations had not been completed for 13 unwitnessed falls (including two with head injury). Neurological observations did not include pupil size and reaction and blood pressure. (vi) Post injury, observations had not been completed regularly over the 24 hour period.</p>	<p>Ensure the following is completed (i) Weights are documented on admission and as required; (ii) Monitoring of pain relief is completed; (iii) De-escalation techniques are documented for individual residents; (iv) Wound assessments are completed; (v) Neurological observations are completed for potential head injuries. (vi) Observations are clearly documented through to the next shift following post incident.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.