

# Milton Adams Limited

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## Introduction

This report records the results of a Surveillance Audit; Partial Provisional 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:

<b>Legal entity:</b>	Milton Adams Limited
<b>Premises audited:</b>	Cromwell House Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 9 February 2016      End date: 9 February 2016
<b>Proposed changes to current services (if any):</b>	Three assisted living units have been converted to make six single bedrooms to increase the hospital level of care by six beds. The service has also increased one bed in the dementia unit, this will change the reconfiguration to a maximum of 50 beds (22 dementia beds, three rest home and 25 hospital level of care)
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	0

# 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
	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

A surveillance audit and a partial provisional audit was undertaken at Cromwell House Hospital. The part provisional audit was included to establish the level of preparedness of the provider to reconfigure the service to add six new hospital level of care beds. With the reconfiguration, bed capacity will increase to 50 beds.

The surveillance audit includes ensuring the service's ongoing compliance with the standards and follows up progress on any shortfalls identified at previous audits. The previous audit identified areas for improvement related to orientation and training, performance reviews, the transcribing of medicines, the call bell system and the hot water temperature monitoring. All these have now been addressed. There is one new area for improvement related to medicine management from this surveillance audit. From the part provisional audit the service is required to ensure all council consents have been gained prior to occupancy of the new area.

The audit process for both the surveillance and part provisional audits included observation of the environment, interviews with the staff, residents, families and clinical coordinators. A review of documented processes was undertaken to ensure these are appropriate for the employment, orientation and training of staff to provide rest home, hospital and specialist dementia care.

## Consumer rights

The residents and family/whanau receive information in a manner that reflects open disclosure. There is access to interpreting services if this is required.

There is a fair and easy to use complaints management system. Complaint forms are accessible and displayed throughout the service. The complaints register records any complaints, dates and actions taken. There are no open complaints

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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## 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.
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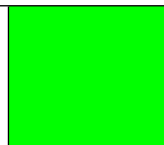
Cromwell House Hospital is a privately owned and run service. There is a clearly documented and displayed organisational mission, vision and philosophy. The direction and objectives of the service are monitored both formally and informally through the business planning documents. There is a transitional plan to reconfigure the six new hospital level of care beds.

The service is managed by a suitably qualified and experienced facility manager. The facility manager is responsible for overall day to day operations of the facility. The facility manager is supported by the clinical team.

The service has sufficient staffing numbers for the commencement of the new level of care requirements. The current staff have either completed or are undergoing specific education related to dementia. The documented human resources management system provides for the appropriate employment of staff and on-going training processes. A system has been developed for the orientation, induction and ongoing education programme. The previous areas for improvement in the human resources, orientation and ongoing education have now been addressed.

## Continuum of service delivery

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



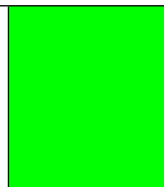
Standards applicable to this service fully attained.

Care plans and evaluations reviewed are completed by registered nurses within the required time frame and demonstrated service integration. Long term care plans are reviewed every six months and short term care plans are consistently developed when acute conditions and behavioural issues are identified. Planned activities are appropriate to the resident's needs and abilities. In interviews conducted residents expressed satisfaction with activities programme in place. There are 24-hour activity plans in the dementia unit in all files reviewed. Meal services are outsourced to an external company and managed by a chef who is responsible for cooking, ordering and serving. Meals meet the individual food, fluids and nutritional needs of the residents.

Medication management system is in place and staffs involved in medication administration are assessed as competent. All medications charts are reviewed by the GP every three months. No evidence of transcribing from all records sampled. An improvement is required regarding signing of medications after administration.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

The service has renovated a previous assisted living area to add six new hospital level of care rooms. There are documented emergency management response processes which were understood and implemented by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances. There are appropriate cleaning services, with the laundry being conducted by an off-site contractor.

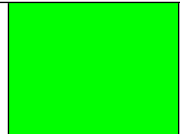
The existing buildings have a current building warrant of fitness and approved evacuation scheme. There are no changes required to the approved evacuations scheme. The final sign off for the council certification has yet to be gained at the time of audit, this will be required prior to commencement of services in the renovated area.

The new section is in the final stage of fit out, and is already furnished. The area is suitable for the needs of the hospital level of care resident. There are designated lounge and dining areas that meet residents' relaxation, activity and dining needs. There are adequate toilet, bathing and hand washing facilities in the renovated area. The new area is suitably heated, cooled and ventilated.

The new area will have a pendant and pager call system. There are appropriate processes and resources in place in the event of an emergency.

The previous area for improvement related to the monitoring of the hot water temperatures and ensuring the call bell system was functioning in the dementia unit are now addressed.

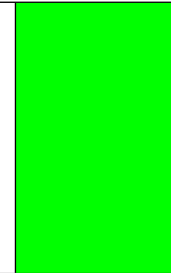
## Restraint minimisation and safe practice

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. There were no residents using restraint or enablers at the time of the audit. 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.

There are no changes required to the infection control programme. The infection prevention and control policies, procedures and programme sighted identified how the provider intends to provide a controlled and safe environment.

The service conducts monthly surveillance of infections. The data is also externally bench marked quarterly. There are minimal recorded infections for 2015. When there has been an increase in the number of infections, actions are implemented to reduce their reoccurrence.

## 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	23	0	2	0	0	0
<b>Criteria</b>	0	57	0	2	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)
<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 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication</p>	FA	<p>The residents and family/whanau reported they have a right to full and frank information and open disclosure from service providers. The incident forms sighted record that the family are notified of the incident/accident. The residents' files provided evidence of family/whanau communications sheets.</p> <p>All residents are able to effectively communicate with the staff. Where there are different languages, there are staff who are able to communicate in the resident's first language. Interpreters are able to be accessed where necessary and staff can be used as interpreters.</p>
<p>Standard 1.1.3: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There are complaints forms available and displayed. The complaints policy complies with, and is referenced to, Right 10 of the Code of Health and Disability Services Consumer's Rights. The complaints sampled were addressed within time frames identified in Right 10.</p> <p>The complaints register records the name of the complainant, who received by, the nature of the complaint, date, date actions to be taken, date actioned, if advice process was commenced and the outcome/closed off date. The 2015 complaints were contained in a section of the complaints folder, the December 2015 internal complaints have not yet been recorded on the register. This was</p>

		actioned at the time of audit and no further action is required.
<p>Standard 1.2.1: Organisational Management</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Services are planned to meet the needs of the residents. The service is in the final stages of converting an existing three bed assisting living wing (upper level of the hospital) to make six more hospital level of care beds. The service has also previously added one additional bed to the secure dementia unit, which did not require a part provisional audit. The dementia unit is divided into two separated wings. Currently there is 22 bed dementia beds, three rest home beds and 19 hospital level of care beds. After the renovations are complete there will be a maximum of three dedicated rest home beds in the same building as the dementia wing, 22 dementia level of care and 25 hospital level of care (these can be used as dual purpose and can be used as rest home level of care if required). At the time of audit there were two rest home, 16 hospital level of care and 20 residents living in the dementia unit. There was one resident in the dementia unit that was under the age of 65.</p> <p>The organisation is privately owned/operated and governed by the directors. The mission, vision and goals of the organisation are displayed and documented in the 2015 'Business Plan and Staffing Rotational Plan'. The 2016 plan is currently under review and in draft format. The facility manager develops the annual business plan, organisational risks and quality goals. Organisational performance is monitored regularly through a monthly report to the directors. These report on all quality related data, staffing, occupancy, risks and key components of service delivery.</p> <p>The services is managed by a suitably qualified and experienced facility manager. Their job description was sighted and confirm accountabilities, authorities and responsibilities. The manager has been in the role for over seven years. The manager has a background in nursing and aged care assessments. The facility manager has over eight hours annually of professional development activities related to the aged care sector. The facility manager is supported by a clinical team that includes the clinical leader and registered nurses.</p> <p>The residents and family/whanau report satisfaction with the care and service delivery at Cromwell House.</p> <p>Part Provisional:</p> <p>There is a draft business and staff rotational plan for the transition for the increased number of hospital level of care residents. This is planned to ensure</p>

		the needs of all residents are met.
<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 quality plan and internal audit schedule covers all aspects of service delivery. The business risk management plan covers being a good provider, responsible planning, safe environment, and internal audits. The organisation has a quality and risk management system which is understood and implemented by staff; with any areas for improvement discussed at staff meetings. The staff confirm knowledge of the quality systems.</p> <p>The policies are developed by an aged care consultant, which are then personalised to the service. The policies and procedures are aligned with current good practice and service delivery. Policies are reviewed at least two yearly, or sooner if there are legislative changes. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff.</p> <p>The internal audit system reviews practices and the key components of the service delivery. Internal audits were sampled for 2015. The RN reports the quality improvement data, results from internal audits and areas of required improvement are reported back to them through the staff meeting and reports to the directors. Corrective action plans (part of the internal audit form) are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. The internal audit form records the review of the actions implemented to ensure these are effective in minimising or eliminating the area of concern. The quality data related to infections is externally benchmarked.</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted includes the identified risks, how these are monitored, and the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risk register is maintained by the facility manager. The risk register is maintained for each area of the service. The service has developed a risk management plan during the renovations of the facility.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The RN (clinical leader) reported that there have been no adverse events that have required essential notification. The RN is aware of their responsibilities for essential notification, which includes reporting stage 3 and above pressure injuries.</p> <p>The incident form records adverse, unplanned, or untoward events. The incidents are collated, analysed and tended on a monthly basis. The service uses this analysis to identify any shortfalls, to make improvements to service delivery, and to identify and manage risk. The adverse event reports include a summary of the incident, immediate actions, corrective actions and outcomes. The follow up includes a re-audit of the implemented actions to review if the hazard has been controlled or eliminated.</p>
<p>Standard 1.2.7: Human Resources Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>. The previous audit identified areas for improvement relating to induction/training for cleaning staff and annual performance reviews. These areas are now addressed. The induction and training for the cleaning staff includes the management of waste and hazardous substances, emergency procedures, infection control and management of challenging behaviours. Performance reviews were sighted in the files reviewed. There is a staff appraisal planner that records that all performance reviews are up to date and flagged as to when they are next due in 2016.</p> <p>Professional qualifications are validated on employment and annually. Annual practising certificates were sighted for all staff and contractors who require them.</p> <p>There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The staff files reviewed demonstrated appropriate recruitment and employment processes. The recruitment and employment process includes advertising, interview process, reference checking, police vetting and qualification validation.</p> <p>There is a performance appraisal system, which is conducted at least annually for all staff. The newer staff also have a performance review after the first two weeks, six months and then annually.</p> <p>New staff receive an orientation/induction programme that covers the essential components of the service provided. The staff files evidenced an orientation has occurred.</p> <p>There is an annual training calendar, with records of attendance maintained.</p>

		<p>The completed annual training time table for 2015 was sighted, as well as the planned education for 2016. The education provided in 2015 was appropriate to dementia, rest home and hospital level of care. The service also accesses ongoing education from external providers, through the DHB and hospice. The attendance sheets and individual staff attendance certificates confirmed the education and training provided meets the contractual requirements and relevant topics to meet the staff needs. Staff in the dementia unit have either completed or enrolled in the required dementia level of care unit standards. The activities coordinator has completed training related to dementia and is currently enrolled in the national qualification in diversional therapy. Two of the RNs have interRAI training and ongoing competency requirements.</p> <p>The residents and family/whanau report satisfaction with the level of skill of the staff at Cromwell House.</p> <p>Part Provisional:</p> <p>The service has already recruited and employed an additional RN. There are no changes required to the education programme, as the service already covers relevant education for hospital level of care.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing rational policy sighted is based on safe staffing numbers and skill mix. The staffing numbers/hours are based on contractual requirements and safe staffing guidelines. There is at least one RN and a member of staff with a first aid qualification on duty at all times. The service has a mix of 12 hour and shorter shifts to ensure there is a greater amount of staff available at the busiest times throughout the day. There are RNs and the facility manager on call after hours for additional advice and support.</p> <p>In addition to the care staffing/nursing rosters there are adequate cleaning, activities and maintenance/gardening staff. The kitchen and laundry services are provided by a contracted company.</p> <p>The residents and family/whanau report satisfaction with the availability of staff.</p> <p>Partial Provisional:</p> <p>The facility manager has a draft transition plan to review the staffing allocation with the increase in hospital level of care. As the renovated/new hospital beds will be on the upper level, there will be at least one staff member allocated to the upper level at all times. The draft staffing allocations records the increased amount of care staff and nursing staff. The service has already recruited an</p>

		additional RN and there are an adequate number of care staff to manage the increase in resident numbers.
<p>Standard 1.3.3: Service Provisional Requirements</p> <p>Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.</p>	FA	<p>Files reviewed identified that an initial nursing care-plan and long term care plan were completed within the required time frame. InterRAI assessments are completed within three weeks of admission and care plans are reviewed every six months or when there is any significant change. Medical reviews are completed by the GP monthly if stable or as required. Short term care plans are developed in the event of any significant change with detailed interventions to guide treatment and resolution dates documented and closed out.</p> <p>Files reviewed identified integration of other health staff and team approach was clearly evident. The observed handover confirmed that adequate and appropriate information was shared between nurses and staff. The other health staff interviewed confirmed that they are updated daily regarding the resident's condition. Residents and family interviewed confirmed involvement in the assessment, planning and review process. Progress notes are written every shift or more often if there are any changes.</p> <p>Three resident records were sampled in detail.</p> <p>The hospital level resident identified developed an acute infection. A detailed short term care plan was developed by the RN with the appropriate interventions to address the problem. The GP was informed and prescribed a course of antibiotics. Presenting signs and symptoms were documented and nursing observations completed. A specimen collected, confirmed the provisional diagnosis. The family were informed and affirmed satisfaction with care given to the resident during interview. Staff interviewed demonstrated awareness of the resident's condition and current management plan.</p> <p>The dementia resident sustained a skin tear which became extensive and infected. There was evidence of wound assessments and behavioural assessments completed as resident at times resists cares. A short term care plan was developed by the registered nurse with appropriate interventions in place. The GP was informed and prescribed a course of antibiotics and pain relief. Progress notes were updated and observations completed. Family were notified regarding the resident's condition. Other referral service providers were notified and a district nurse continued to provide input on the wound management plan to be followed and reviewed it periodically. Wound care plans and a 24-hour dementia care plan were sighted. Staff members were</p>

		<p>knowledgeable regarding the management plan of the resident. The wound is currently in the end stage of the healing process.</p> <p>The rest home resident experienced periods of loneliness as she has no family unlike other residents who have regular visitors as narrated during interview. Required assessments were conducted by the registered nurse and activities coordinator respectively. The resident is supported and encouraged to join in group activities and at times one on one sessions. Various activities are in place and individualised to cater for the resident's preferred needs. All regular reviews by the GP are up to date and individualised activities are evaluated timeously to remain relevant to resident's needs. The resident was interviewed and appeared satisfied with nursing care provided and verbalised that staff are always supportive and ready to engage in any conversation to keep the resident company. Staff were aware of the resident's condition. The activities coordinator confirmed there are various activities in place to keep the resident stimulated to prevent boredom for example bus rides, happy hour, ice-cream days, group activities which helps in creating a good rapport with others.</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>Documented interventions are sufficiently detailed to address the assessed needs and desired goals/outcomes. The interventions in managing acute infections are documented in the short term care plans. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily. Resident's files had activities of daily living documented and completed daily. Monthly observations were completed and up to date.</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>Activities are appropriate to the needs, age and culture of the residents. The activity coordinator develops an activity planner and daily/weekly activities are posted in the two main lounges notice boards. Resident's files have a documented activity plans that reflect the resident's preferred activities of choice. Over the course of this audit, residents were observed being actively involved with a variety of activities and those interviewed expressed satisfaction with activities in place. Individualised activity plans are reviewed six weeks post formulation to evaluate effectiveness and six monthly or when there is noted decline in participation. The activities coordinator reported that they have group activities and engage in one on one sessions with some residents. The activities coordinator receives support from the manager, staff and is currently enrolling for a course in diversional therapy.</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 long term care plans are evaluated in a comprehensive and timely manner at least six monthly and updated if there is any significant change. Reviews are fully documented and include current resident's status, any changes and achievements towards goals. Family/whanau, staff input is included in all aspects of care and is reviewed/evaluated. Short term care plans are developed as when necessary.</p>
<p>Standard 1.3.12 Medication 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 Low</p>	<p>The medicine management system is implemented to ensure that residents receive medicines in a safe and timely manner. All medications are reviewed as required and discontinued medications are signed and dated by the GP, allergies are documented, and photos present, three monthly reviews are done. Medication charts were legibly written. The RN was observed administering medications correctly. Medications and associated documentation are stored safely and securely and medication reconciliation are conducted by RNs when resident gets transferred back to service.</p> <p>The service uses an individualised robotic packs which are checked by RN on delivery. The controlled drug register is current and correct. Weekly stock takes are conducted and all medications stored appropriately. There were no residents who self-administered their medications and self-administration policies and procedures are in place. The proposed medication room sighted in the new wing which is safe and secure.</p> <p>An annual medication competency is completed for all staff administering medications and medication trainings conducted. An improvement is required regarding signing for medications after giving them to residents.</p>
<p>Standard 1.3.12.1 Medication Management</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>A medicines management system is not consistently implemented to manage the safe and appropriate administration in order to comply 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 is a component of service</p>	<p>FA</p>	<p>Meal services are outsourced to an external company. The service employs two chefs and all have current food handling certificates. The menu was reviewed by a dietitian to confirm it is appropriate for the nutritional needs of the residents. Meals are prepared in the kitchen and served to residents in the</p>



<p>delivery.</p>		<p>hospital and dementia dining rooms respectively. Diets are modified as required. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. Resident's weight is monitored regularly.</p> <p>Supplements are provided to residents with identified weight loss issues. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring are maintained. The kitchen cleaning schedule is in place which is signed off by the chef daily. The residents and family interviewed indicated satisfaction with the food service. Satisfaction survey indicated that residents are happy with the meals provided.</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>Part Provisional:</p> <p>There are processes in place for the management of waste and hazardous substances for the renovated area. The current process for management of waste, infections or hazardous substances will be implemented. The renovated area has waste and laundry skips to allow the transporting of the waste to the current garbage and laundry storage areas. Personal protective equipment is available for use in the laundry and sluice rooms. The cleaner demonstrated knowledge on infection prevention and control and the use of personal protective equipment.</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>PA Low</p>	<p><b>Evidence:</b></p> <p>The previous audit identified that the system for reporting hot water temperatures did not ensure corrective actions are implemented if the temperature exceeds a safe level. This is now addressed, the sighted recordings for 2015 were below the required 45 degree Celsius. Some reading for January were above the required temperature, with actions implemented recorded for when the hot water temperature exceeds 45 degree Celsius.</p> <p>There are current building warrants of fitness for the buildings. The secure unit is recorded as expiring in 26 June 2016 and the hospital building in 2 December 2016.</p> <p>The one additional room in the secure dementia unit (was a rest room) provides suitable space for the resident.</p> <p>Partial Provisional:</p>

		<p>The service has yet to gain the council requirements for the occupation of the renovated area. This will be required prior to occupancy.</p> <p>The service has a planned renovation, construction and extension programme to add an additional six hospital beds to the service. The service has a comprehensive risk management plan to address potential issues during the renovation and construction. The structural work and fit out of the refurbishment is completed. The final wiring and installation of the central heating system is being installed on the day of audit.</p> <p>All the electrical and medical equipment in the refurbished area is newly purchased. The ongoing test and tag of electric equipment is included in the maintenance programme. The hot water temperatures in this new area are part of the monthly hot water checks.</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents at hospital level of care. The renovated area is on the upper level and there is a lift and a chair lift on the stairs. The service has also purchased a stair trolley, which can be used to assist residents down the stairs if there is a power shortage or emergency.</p>
<p>Criterion 1.4.2.1: All building, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p><b>Evidence:</b></p> <p>The service has yet to gain the finalised council certification (or written advice that confirming one is not required), before the service can use the renovated area for hospital level of care.</p> <p><b>Finding:</b></p> <p>The final council certification has yet to be issued.</p> <p><b>Corrective Action:</b></p> <p>Ensure the council consents are gained prior to occupancy.</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</p>	<p>FA</p>	<p>Part Provisional:</p> <p>For the six residents there are two bathrooms. One of these bathrooms is large enough to fit the shower trolley. The bathroom areas are in addition to the existing toilet and showers in the rest of the facility. The bathrooms have appropriate privacy locking systems and signage.</p>

hygiene requirements.		
<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>Part Provisional:</p> <p>The renovated area provides safe, adequate, age appropriate areas for relaxation, activities and dining. There is a separate lounge and dining area in the upper level. There are decks and the residents can access the existing external area by the lift, stairs or stair lift.</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>Part Provisional:</p> <p>The laundry service is conducted by an external company. The cleaning is done by a roistered cleaner. The cleaning schedule already includes the new area. There are processes in place to transport the cleaning trolley and laundry to and from the upper level. There will be no chemicals stored in the new area. The current chemical storage room will be used. When the cleaning trolleys are not in use, these are stored in the cleaner's room. All chemicals sighted are adequately labelled with the suppliers labels.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security System</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The previous audit identified that although there are security cameras in the dementia unit, the call system is inconsistent and not working effectively in some areas. This has now been addressed with a call pendant/pager system. The resident wears a call pendant and when activated alerts the care staff and RN that the alarm has been activated. The systems is working on the day of audit.</p> <p>Part Provisional:</p> <p>The evacuation scheme was approved by the fire service (12 April 1999). There are no changes required to the approved scheme as there has not been any changes required to this approved evacuation scheme.</p> <p>Fire training occurs six monthly, with the last conducted in December 2015. The contracted fire service conducts a monthly inspection of the fire equipment and evacuation routes.</p> <p>The refurbished area will also have the same call pendant/pager system as the secure dementia unit.</p> <p>In the event of a power outage or if the lift can not be used, the service has a chair trolley to enable the residents to be transported down the steps if the</p>

		<p>resident is not able to use the stairs.</p> <p>The service has access to an adequate amount of food and drinking water in the event of a civil defence or emergency situation. There is backup gas supply for cooking and a civil defence kit for emergency supplies.</p>
<p>Standard 2.1: Restraint Minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Staff actively work to minimise the use of restraint through use of call bell system, falls risk assessment forms. All staff receive education regarding restraint minimisation and staff interviewed demonstrated knowledge regarding the difference between restraint and enabler use. An updated register was sighted. The service currently has no residents using restraint or enablers.</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>The infection control programme is reviewed annually and is incorporated into the review of the education programme. The programme is evaluated to assess the progress in achieving the goals and objectives. The infection control co-ordinator reports to the staff and facility manager on all aspects of infection prevention and control. Infection control is a standard agenda item at the monthly staff meetings.</p> <p>There are processes in place to prevent staff and residents exposing others when they are unwell. Staff are encouraged not to come to work if they are unwell. There are processes in place to isolate infectious residents if this is required. There are notices on the doors to advise visitors not to visit if they are unwell. Sanitising hand gel is available at all entrances.</p> <p>The roles and responsibility for the infection control coordinator is defined in their position description (sighted). Staff interviewed knew that they are required to report residents who are suspected of having infections to the RN promptly. Staff were able to identify the importance of hand hygiene and using standard precautions</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The type and frequency of surveillance is clearly stated in policy and is appropriate to the complexity of the organisation. Surveillance methods, analysis and responsibilities are clearly described within the infection control policy. An annual summary of the number and type of infections per month is maintained and sighted for 2015. The service conducts quarterly benchmarking with an infection control consultancy agency.</p> <p>The data for 2015 records minimal infections. A register is kept of all residents who develop infections, the type of infections, results of cultures (where</p>

		obtained) and details of treatment provided. The register notes whether further follow-up is required. The data is imputed into the computer each month and reports surveillance data at monthly staff meetings. Staff reported they are notified of any infections at handover and families are contacted
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## 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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Five of the 11 medicine sheets reviewed were not fully completed at each medicine administration.	Ensure all medications given are signed for per every medication administration round	180 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	The final council certification has yet to be issued.	Ensure the council consents are gained prior to occupancy.	Prior to occupancy

## 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.

No data to display
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End of the report.