# Rosewood Resthome Limited - Rosewood Resthome and Hospital

## Introduction

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

The audit has been conducted by The DAA Group 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:

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| **Legal entity:** | Rosewood Resthome Limited |
| **Premises audited:** | Rosewood Resthome and Hospital |
| **Services audited:** | Hospital services - Psychogeriatric services; Dementia care |
| **Dates of audit:** | Start date: 27 July 2016     End date: 28 July 2016 |
| **Proposed changes to current services (if any):** None | |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** 63 | |

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| Indicator | Description | Definition |
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| | 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

Rosewood Rest Home and Hospital provides rest home and hospital level care for up to 66 residents in three separate units - a 26 bed dementia specific unit and two 20 bed psychogeriatric hospital units. The service is operated by Rosewood Rest Home Limited and managed by a suitably qualified facility manager with support from a general manager and a clinical service leader. A registered nursing team oversees day to day care.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family/whānau, the owner and management, care and household staff, a contracted podiatrist, visiting wound care nurse and a general practitioner.

This audit has resulted in a continuous improvement rating for the evaluation and review of service delivery plans and identified four areas requiring improvement relating to residents' food and nutrition; food delivery, storage and preparation; infection control management; and cleaning practice.

# Consumer rights

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| 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. | <span style="background-color:green">     </span> | Standards applicable to this service fully attained. |

Consumer rights are being upheld by the service provider. The Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights (the Code), is on display near the entrance and a copy of the Code is provided to residents and their family/whanau on admission to the service, as is information on the Nationwide Health and Disability Advocacy Service.

A Maori Health Plan and related organisational policy and procedure documents are in place. The cultural needs of Maori residents are being recorded in their files as are other cultural needs of residents.

Family members informed that open disclosure is occurring and this was verified in accident and incident report documentation. Staff use a range of techniques to communicate with the residents, many of whom have special needs. They are vigilant about maintaining the privacy and dignity of the residents and there is no evidence of any form of discrimination or harassment.
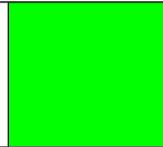
Staff were observed respecting residents' rights during service delivery, encouraging independence and allowing them to make personal choices. Records show that they are acknowledging and supporting cultural, spiritual, emotional and individual rights and beliefs, which was confirmed by family members.

Legal documentation in relation to enduring powers of attorney is in place and consent forms are being signed as required. There is access to independent advocacy services, although family members or welfare guardians generally take on this role. Visitors are welcome and came and went freely during the audit.

The facility manager is responsible for the management of complaints. A complaints register that meets the requirements of the Code is maintained.

# Organisational management

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| 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. | <span style="background-color:#00ff00">    </span> | Standards applicable to this service fully attained. |

Rosewood Rest Home Ltd is responsible for the service provided at this facility.  The owner is regularly on site.  Business and quality and risk management plans are documented and include the business and strategic plan, mission statement and governance policy of the organisation are in place for monitoring the services provided, including regular monthly reporting to the general manager by the facility manager, and clinical nurse leader at the management meeting.

A comprehensive quality and risk management system is in place with a robust reporting system.  The quality improvement plans include an annual calendar of internal audit activity which has been completed. Collection, collation and analysis of quality improvement data is occurring. Collated clinical data is reported to the management and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes and graphs of clinical indicators are used to inform staff about the effectiveness of care delivery. Adverse events are documented on accident/incident forms and entered into an electronic system to facilitate trending patterns. Corrective action plans are consistently being developed, implemented, monitored and signed off when completed. Risks are identified and mitigated and the risk register is up to date. A suite of policies and procedures are current and are reviewed regularly. Resident and family surveys have been conducted.

Human resources management policies guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role as specified in the contract.  Regular in-service education is provided and well attended. Staffing levels and skill mix meet contractual requirements and the needs of residents. There is a roster of senior staff on call out of hours.

Residents' records are locked in nurses' stations, all entries into residents' records are entered according to legislative requirements and an integrated record system is in place.

# Continuum of service delivery

| | | 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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| 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. | | |

Entry to the facility is contingent upon the person being assessed as requiring rest home dementia services or psychogeriatric care. Admission processes and documentation is being completed within required timeframes. InterRAI assessments and a range of other specialised assessments are used to identify the goals for the service delivery plans. A clinical manager and a team of other registered nurses oversee the caregivers and are responsible for the assessment, planning and review processes and for the associated documentation. Relatives are involved in care plan development and there is good evidence of multidisciplinary team involvement, including with external professionals. Short term care plans are developed when short term conditions and needs arise. Family members interviewed were very positive about the high level of care and support provided to the residents.

Individualised activity plans are complemented by 24 hour activity plans. A variety of activities are provided with one-on-one time and community options included in the monthly programme.

Evaluations and reviews of short term, long term and activity plans are comprehensive and occurring at regular timeframes. Amendments are made to interventions and goals when the need for change is identified.

Medicines are being managed according to policies, procedures and guidelines for safe practice. Those administering medicines are assessed as competent to do so on an annual basis.

Foods are prepared according to a four week rotational menu that has been developed in consultation with a dietitian. Recording systems are in place for the checking of fridge and freezer temperatures, the temperatures of hot food and for the delivery of chilled food. The needs of residents with special dietary needs are being managed.

## 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. | | Some standards applicable to this service partially attained and of low risk. |
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The facility has some original features and newer areas which are purpose built.  All building and plant complies with legislation and a current building warrant of fitness is displayed.  A preventative and reactive maintenance programme is implemented. There are two double rooms, with the remaining being single rooms, most of which have shared ensuite bathrooms.  Rooms are of adequate size with sufficient space for equipment and storage.  Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite in two laundry areas, with monitoring to evaluate effectiveness of the processes.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire.  Access to an emergency power source is available. Security is maintained throughout the building and grounds by means of keypad entry locks.

## Restraint minimisation and safe practice

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| 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. |

Restraint use is minimised and there is a focus on de-escalation and behaviour management. Policies and procedures on restraint minimisation and safe practice meet the requirements of the standard. A restraint committee and restraint coordinator oversees and monitors restraint use. The current use of restraints is being assessed, monitored, evaluated and reported as required.

## Infection prevention and control

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| 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 is a managed environment for infection prevention and control led by an appropriately trained infection control coordinator with a clear role description.  The annual infection prevention and control programme is under review and a committee structure developed. Specialist infection prevention and control advice is able to be accessed from the district health board and a community microbiologist.

Aged care specific infection surveillance is undertaken, analysed and trended in the on line system. Data is now being entered on a regular basis and results of surveillance reported through all levels of the organisation. A recent infection outbreak, confirmed as norovirus, was adequately managed.

# Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|---|---|---|---|---|---|---|---|
| Standards | 1 | 46 | 0 | 2 | 1 | 0 | 0 |
| Criteria | 1 | 95 | 0 | 2 | 2 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|---|---|---|---|---|---|
| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation. | FA | A Code of Rights policy also includes residents' right to dignity and independence. Family members and external providers expressed their belief that residents' rights are being upheld with many staff going beyond the call of duty to support the residents. Staff were observed demonstrating respect, patience, giving the residents options and enabling them to be as independent as they were able. |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Organisational policies and procedures and relevant forms are available in relation to informed consent, advance care planning, resuscitation and advance directives. These include details about managing situations when a person is not able to give informed consent and the requirements around enduring power of attorney/welfare guardianship.<br><br>During the review of residents' files, all except two of those sighted included completed consent forms that were signed by a legally appointed enduring power of attorney (EPOA), or welfare guardian. Communication documentation on files demonstrated that both exceptions were recent admissions and the paperwork was underway.<br><br>There were no detailed pre-admission advance directives in the files that were reviewed. However, those reviewed included a form stating that the person was not competent to make their own decision regarding such actions and that such a situation had been discussed with the resident and/or the |

| | | EPOA. The recommended level of interventions in an emergency were noted and signed by the person's current GP. |
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| Standard 1.1.11: Advocacy And Support<br><br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy on advocacy states the service will provide links to the advocacy service and local phone contacts are detailed in the policy. Because all residents in this facility have dementia at one level or another, relatives are their primary advocate. Family members confirmed they feel listened to when they express concerns, or speak up on behalf of a resident. Staff provided examples whereby a visiting advocate has been asked to be involved in supporting residents as family members were not available. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br><br>Consumers are able to maintain links with their family/whānau and their community. | FA | Visitors confirmed during interview that they are free to come and go as they choose and are always made to feel welcome by the staff and managers at Rosewood. During the audit visitors came and went and staff were repeatedly observed conversing with them. A communication record is being maintained for each resident and sits near the front of their personal files. These are informative and demonstrate good links with family/whanau.<br><br>Entertainers, local priests and ministers of the church and volunteers provide links with the community. Likewise, external professionals such as podiatrists, specialist nurse and GPs also provide links. The residents are taken for van rides if they choose, and as far as they are able, at least once a month. Rosewood rest home and hospital residents are known in the local community as they visit a local shopping mall for morning or afternoon tea on a weekly basis in warmer weather. |
| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints/concerns policy meets the requirements of Right 10 of the Code and describe the right to complain, methods of complaining and how the complaint is managed in the first instance. Investigation, notification and resolution are described. Formalising informal complaints may be addressed by raising these formally or as a quality improvement/corrective action.<br><br>Information about how to complain is provided to residents and family/whānau on admission and complaints information and forms are available in each area of the facility.  Five documented complaints received in the past year were reviewed from the complaints register.  These indicate all actions are taken through to an agreed resolution, are fully documented and completed in the timeframes specified in the Code.  Quality improvements have been initiated where appropriate.  The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. |

| Standard 1.1.2: Consumer Rights During Service Delivery<br><br>Consumers are informed of their rights. | FA | Information about the Nationwide Health and Disability Advocacy Service is displayed on the wall alongside the Code of Health and Disability Services Consumers' Rights (the Code). Copies of brochures on residents' rights and advocacy services are in the admission pack provided to relatives when a resident is admitted. Staff informed that these are explained to relatives and as far as possible to the residents, on admission and this was confirmed by relatives. |
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| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Policies on abuse and neglect, sexuality and intimacy, and spirituality were sighted. Issues around privacy and dignity are covered in a confidentiality and privacy policy. Contact details for referral agencies are available and these are being used when required.<br><br>A personal profile of each resident is developed on admission and guides staff in assisting residents to have their cultural, religious, ethnic and social needs met. Examples of these being followed through were observed and read in progress reviews.<br><br>Residents are given time to undertake tasks that supported their independence, or reflected tasks of their lives prior to admission, such as folding laundry and dressing themselves, even if they required assistance to complete them later. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>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. | FA | A policy covers ethnicity awareness, a definition of culture and cultural safety and the Treaty of Waitangi. Detail includes acknowledgement of the Ministry of Health Maori health strategy and priority areas for health. Links to Maori health providers, training and interpreters and a glossary of terms are included. 'Te Whare Tapa Wha' and generic cultural care intervention are described in that policy that is complemented by a Maori Health plan.<br><br>The organisation's overall commitment to family/whanau inclusion is reportedly working well for two families of residents. Family/whanau, specific Maori cultural needs and the use of te reo Maori is documented in the relevant section of the care plans of those who identify as Maori, two of which were sighted. Family/whanau of Maori residents have not identified the need for additional external resource from the local Maori community to be involved at this point. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe | FA | The policy on culturally safe care meets contractual requirements.<br><br>A link to 'You Tube' about spirituality for people with dementia is documented and residents are supported to attend church within the community if they choose and an example was provided. An in-house interdenominational service is provided once a month and visiting priests and other preachers |

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| services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | | come and go as time avails them. Examples of staff respecting individual values and beliefs were observed and these were supported by documentation sighted. Singing, speaking in their own language, discussing sport, daily provision of the newspaper and personal items in their rooms that reflect personal preferences were some examples. |
| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There is an organisational human rights and harassment policy and a social media policy. The code of conduct for nurses is included, as is reference to caregiver conduct and professional boundaries in the orientation handbook.<br><br>Feedback from relatives and visiting professionals and observations made on the day of audit confirmed that service providers are maintaining professional boundaries. There was no observable evidence of abuse, harassment or neglect of residents and nor were there any reports of such actions during interviews or reviews of records. |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | FA | Staff reported that the leadership and support they receive from the general manager filters through all levels of the organisation and encourages them to maintain what they understand to be best practice and to fulfil the ideals given them during their training sessions. High levels of commitment and passion of the staff delivering services were observable and were consistently confirmed by relatives during interview. The calm environment within this dementia setting was testament to these reports, as was the quality improvement project that was implemented to address concerns around meals, the willingness for staff to undertake additional training and the completeness of the care planning, for example. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A policy on open disclosure references the Code, the complaints policy and staff orientation. Relatives confirmed during interview that open disclosure is occurring and there was evidence of this in the communications record sheets in residents' files. Staff were heard explaining situations to residents regardless of their level of dementia.<br><br>Residents with different communication needs, such as English not being their first language, or with hearing impairment, have their requirements noted in their files. There are details on how to access local interpreter service, however staff informed that to date family members or staff have been able to meet the needs of the residents. |

| Standard 1.2.1: Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans outline the philosophy, mission and values of the organisation. The documents describe annual and longer term objectives and the associated operational plans. Manager and director roles are described. The general manager (GM) and owner meet regularly. The facility manager provides a structured monthly report against key performance indicators to the general manager. The regular on site involvement of the owner and GM ensure any matters are brought to their attention at an early stage. A sample of reports reviewed shows adequate information to monitor performance is reported including for example, clinical indicators, occupancy, emerging risks, incidents, accidents and complaints.

The service is managed day to day by the facility manager. She holds relevant health professional qualifications and has undertaken relevant postgraduate study and attended aged care conferences. She has been promoted to the facility manager role after filling the clinical leader position for four years. The GM is suitably skilled and qualified for the role and is a trained psychiatric nurse with an extensive background in dementia care. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Both managers confirmed knowledge of the sector, regulatory and mandatory reporting requirements.

The facility manager is supported by the clinical nurse leader and assistant clinical leader. Together with the registered nurse team, the day-to-day operation is managed effectively. This leadership team and other committees meet monthly. Meeting minutes reviewed confirmed comprehensive reporting and discussion on incidents, complaints, audit activity, policy development, health and safety, staffing issues, emerging issues and infection surveillance results.

On the days of audit, the psychogeriatric service is fully occupied (40 beds) and there are 23 residents in the secure dementia service. |
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| Standard 1.2.2: Service Management

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. | FA | When the facility manager is absent, other members of the of the leadership team carry out all the required duties. The GM is available for advice and support, as her time is spread between two facilities. During absences of key clinical staff, clinical management is overseen by one of the clinical leaders who are experienced in the sector and are able to take responsibility for any clinical issues that may arise. |
| Standard 1.2.3: Quality And Risk | FA | The organisation has a quality and risk system that reflects the principles of continuous improvement |

| Management Systems

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | | and is understood by the staff interviewed.  The facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows consistent review and updating of high risks (or when risk ratings change), risk plans and the addition of any new risks.  The risk register sighted was current for each area of the service. The organisation has recently achieved the ACC Workplace Safety Management Practices accreditation to tertiary level.

Reporting and management of incidents and complaints, audit and monitoring activities, a regular resident and family/whānau satisfaction survey, clinical indicators (such as infections, falls and pressure injuries and use of restraint) are regular agenda items at meetings.  Key quality indicator results are analysed and collated by the team to inform the quality cycle. Relevant corrective actions are developed and implemented as necessary. The quality process – 'plan-do-check-act' (PDCA) is the preferred quality process used to address all issues that are identified as needing a response. Review of these demonstrate a continuous process of quality improvement is occurring. Information is shared across the organisation via the various committees.  Resident and family surveys are completed annually.

Policies reviewed are comprehensive and current with regular reviews occurring. A document control system is in place, with draft status noted as appropriate. All staff are expected to read all new and revised policies to ensure they fully understand any changes and updates that are made. Document development is undertaken by a contracted external provider. |
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| Standard 1.2.4: Adverse Event Reporting

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. | FA | Staff document adverse and near miss events on an accident/incident form. Residents' documentation reviewed provided evidence of communication with family/whānau and those holding enduring power of attorney (EPOA) following an adverse events involving the resident.  Changes in the resident's condition are also communicated in accordance with the open disclosure policy with this process confirmed at interview with family members.  A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner.  Adverse event data is collated, analysed and responded to by the facility manager and reported in the monthly management and staff meetings.  Minutes are maintained.

Policy and procedures describe essential notification reporting requirements (eg, pressure injuries, health and safety, human resources, infection control).  Staff confirmed they are made aware of their notification responsibilities through job descriptions.  The facility manager advised there have been no notifications of significant events made to the Ministry of Health since the previous audit apart from a coroner notification which was later withdrawn. A notification to the Medical Officer of Health was made for a recent norovirus outbreak. |

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| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures are in line with good employment practice and relevant legislation guide human resources management processes. Position descriptions reviewed are current and define the key tasks and accountabilities of staff. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Records of these are maintained and updated and examples of registered and enrolled nurses, general practitioners, podiatrist and pharmacists reviewed were current. A sample of 12 staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Staff files are systematically organised with all relevant information included.<br><br>Staff orientation includes all necessary components relevant to the role. Staff reported feeling well supported through their initial orientation period. Staff records reviewed show documentation of completed orientation and competencies. Completion of a performance review after a three-month period was recorded and annually thereafter with current competencies linked to the annual appraisal. Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies.<br><br>Continuing education is planned for the year. Mandatory training requirements are defined and scheduled to occur over the course of the year. Of particular value, the organisation has a system to ensure night staff receive the session content from the nurse educator when outside speakers are engaged to deliver staff training. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the providers agreement with the DHB. Two staff members are the internal assessors for the programme. Education records reviewed demonstrate completion of the required training in the required timeframes. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility has staffing levels that reflect the needs of the residents in both levels of care. The minimum number of staff is provided during the night shift and consists of one registered nurse and six caregivers across the service. An afterhours on call roster is in place, with staff reporting advice is available when needed. Care staff interviewed reported adequate staff were available and that they were able to complete the work allocated to them.<br><br>Observations and review of a four-week roster cycle sample during this audit confirmed adequate staff cover has been provided and is in excess of contractual requirements. The organisation seldom uses bureau staff; instead it utilises casual staff to maintain staffing levels and skill mix for short notice roster gaps. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) registered nurse coverage in the hospital. Family interviews confirm adequate |

| | | staffing levels, although pressure can occur over the meal times. |
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| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Information about new residents is entered into an electronic database on entry to the facility. All other care and support information is being entered into a hard copy personal file for each resident. Confidential information about residents is stored in locked nurses' stations with archived records locked away. Assessments, planning documentation and reviews are being completed within required timeframes. Internal audits and staff education have contributed to records being entered into records in a legible manner and include a signature and designation. An integrated residents' record system is in place for each resident with all aspects of their care being recorded in one place. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | A policy on acceptance and entry into the service was sighted. This details entry criteria and assessment processes with a needs assessment and service coordination service (NASC). It also details admission processes including documentation requirements.<br><br>An entry to service package was sighted and is available to people enquiring about the facility as well as being provided to residents entering the service and their families. This package includes key pamphlets on consumer rights and advocacy, an information booklet and the service agreement. All residents are referred through the NASC at Older Persons' Health and may come from a range of living situations, such as direct from their home, one of the local hospitals or another aged care residential service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The clinical manager described one example of a person transferring to another facility. This was described as an open process with two-way communication. Forms are available for transfer to a public hospital and an example of a completed version was sighted. Policies and procedures regarding transfer and discharge processes are in place, as are those for managing any event of a death. Details of managing death and dying were described and were consistent with accepted good practice. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative | FA | Medicines are being managed according to a range of medicine management related policies and procedures. A satisfactory amendment was made to one section of these between stage one and stage two audits.<br><br>A medicine administration round was observed during the audit and expected attention to detail when administering medicines to residents with dementia was upheld. The pharmacy has been involved in |

| requirements and safe practice guidelines. | | updating medication information education and all staff who administer medicines have a current medicine administration competency, which is renewed annually. |
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| | | Medicine records in both the rest home and psychogeriatric areas are being completed and used according to legislation and guidelines with evidence of allergy recordings, details of the resident and their photograph, all medicine orders were signed and dated, any discontinuation had been signed and dated, three monthly reviews were dated and signed, explanations for use of pro re nata (PRN) medicines and evidence of pharmacy involvement. Administration records are being signed and they contain sample staff initials. There is also a staff signing sheet in the front of the medicine records folder in both the rest home and the psychogeriatric areas that sit alongside information on which medicines may be crushed, a reference list for additional information on medicines and a list of standing orders for the respective GP. Administration records are being signed according to protocols following the administration of each medicine. Staff report they are aware of the need to complete an incident form should a medicine error occur. |
| | | As this facility is a dementia service, there are no residents who self-medicate. |
| | | Medicines are stored in locked cupboards in locked rooms and the management of medicines that have additional monitoring requirements meet storage, signing and checking requirements. |
| | | Primarily it is registered nurses who are managing the medicines. Reconciliation processes are undertaken for new residents, for a resident returning from a general hospital visit, for new medicines that are prescribed for a resident and for the arrival of bulk medicines that occur monthly. Signed records were sighted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate | Meals are prepared according to a menu that was developed in April 2016 in consultation with a dietitian. Final sign off was May 2016. Relatives started raising concerns about the quality and quantity of food from late 2015 and residents were losing weight. A quality improvement plan was instituted to address the issues and a variety of approaches tried. There have been some changes made, however further improvement is required. |
| | | Nutritional assessments are being completed for residents and the kitchen is being advised of new requirements, or amendments to requirements, that will meet the needs of residents. Likewise resident's food dislikes are listed. Records were sighted. Sandwiches and baking is available 24 hours a day as per contractual requirements for people receiving care in a dementia facility. |
| | | Improvements are also required around the kitchen environment, food storage and food monitoring processes. |

| Standard 1.3.2: Declining Referral/Entry To Services<br><br>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. | FA | A policy on acceptance/entry to the service includes a section on declining entry. The clinical manager and the rest home team leader both explained that as it is essential for all prospective residents to be assessed by a needs assessment and services co-ordination service, that it would not be usual to decline a person entry. Following an extraordinary circumstance there had however been a situation in which one person was assisted to move elsewhere. This was managed with diplomacy. |
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| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents at Rosewood have a nursing assessment completed to enable the development of an interim/short term care plan. Within three weeks interRAI assessments are being completed in consultation with consenting family members. Residents also have a Coombes assessment for falls risk, a Braden for pressure injury risk, a pain assessment and a nutritional assessment completed within the first three weeks. The long term care plan goals and interventions follow the interRAI triggers. Generic care plan goals are selected according to the interRAI triggers. All residents except for two recent admissions in the hospital and one in the rest home, have a completed interRAI assessment, which depending on their admission date may have been done on admission, or at their six monthly reviews.<br><br>A social profile is undertaken by the activities coordinator within the first three weeks to assess the needs and preferences of new residents. Information from the profile is used to assist with the development of activities plans. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Although a generic template is being used as the format for developing the care plans, the interventions in the care plans follow the person's interRAI results. All care plans are individualised and describe the required support or intervention to meet the identified goals for each person according to their specific needs. There is good evidence of service integration as interventions include information about the involvement of allied health professionals, including diversional therapists, any physiotherapist, diabetes centre input and visiting wound care specialists for example. Responsibilities of registered nurses and of the support workers are clear where both levels of intervention are required.<br><br>Short term care plans are being developed if a short term illness or injury is incurred. These were sighted in residents' files. |
| Standard 1.3.6: Service | FA | Family members and external professionals who visit the facility and were interviewed conveyed only |

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| Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | | positive messages about the care and support provided at Rosewood. There was a calm environment throughout the audit and observations made showed that staff interacted well with residents, acknowledged them in passing and sorted issues such as blankets that had slipped, or spilt food on clothing, for example. Reviews of care plans and progress notes reported directly back on the goals within the care plans. Amendments on the care plans showed that as a person's needs changed so did the services provided. The medical records inform that monthly GP visits are occurring with three monthly medicine reviews and any new information is being conveyed to nursing and subsequently caregiving staff for implementation. |
| Standard 1.3.7: Planned Activities<br><br>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. | FA | The activities coordinators undertake a personal profile with relatives and the new resident shortly after admission. The activity plans include pertinent goals, describe a range of activities in different settings and reflect information from the profile. Each resident has a personalised 24 hour plan, which guides care staff with options when required or applicable. Activity plans are reviewed at the same time as the care plan and activities staff are involved in residents' reviews.<br><br>The activities coordinators were observed undertaking a range of duties and activities with residents and the monthly plan for the rest home and the separate one for the hospital service showed a variety of activities. One on one time is spent with residents and as far as possible usual routines are maintained including newspaper reading in the morning and more relaxed activities and entertainment in the afternoon. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | CI | A strength of the organisation is the ongoing review and evaluation processes. These are operating at a level of continuous improvement within a range of different levels of service delivery. Progress notes are being consistently reviewed each shift and short term care plans are being reviewed daily and transferred to the long term plan in a timely manner when appropriate. There are full care plan reviews every three months and six months. InterRAI assessment results form the basis for the six monthly reviews. Evidence of care plan interventions and goals being changed, or added, is throughout the care plans. Caregivers are being included in the increased focus on evaluation and review and this has resulted in them becoming more pro-active in reporting observed changes to senior staff. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or | FA | The clinical manager explained the referral process. A number of referrals were found within the residents' records that were reviewed. Examples of these included psychiatric services of older persons' health, the diabetes clinic and a referral back to the NASC service. There was also evidence of follow-up reports from previous referrals. Family members informed that the staff and GPs are pro- |

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| referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | | active in ensuring external services are accessed when required and expressed confidence that all required services are being accessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place as part of infection control documentation. No incidents have been reported. The policy includes rubbish handling, kerbside recycling, kitchen waste, medical waste and cytotoxic waste. A contracted provider collects on site waste three times per week.<br><br>The door to the chemical and cleaning store were secured. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff (records sighted for 2016). Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. This was implemented on site. Material safety data sheets were available and accessible to staff.<br><br>Provision and availability of protective clothing and equipment is appropriate to the recognised risks. Protective clothing and equipment was available in key clinical areas (dirty utility, laundry and on cleaning trolleys, treatment rooms). Staff were observed using the protective clothing provided. Outbreak kits are located in each wing. An external contractor provides gardening and spraying services – garden related poisons are not stored on site. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | A current building warrant of fitness (expires 29 March 2017) is publically displayed. An engineer's construction review post-earthquake confirms the buildings are now 70 – 77% of the Building Code requirements.<br><br>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard in most areas although aspects of the physical environment compromise infection control management. The testing and tagging of equipment and calibration of bio-medical equipment is current and records are maintained. Hot water at the tap is maintained at a safe temperature, with regular monitoring occurring. Documentation reviewed, interviews with maintenance personnel and observation of the environment confirmed the systems used.<br><br>External areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Staff and family/whānau interviewed |

| | | confirmed they know the processes they should follow to report the need for repairs or maintenance and that requests are appropriately actioned. |
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| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>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. | FA | There is a mix of shared ensuites with toilets and showers and bathing facilities shared between two rooms. Two communal bathrooms and an additional toilet block service the six rooms without an ensuite in the rest home area. These areas are in need of refurbishment (refer corrective action request 1.4.2.4). Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Two rooms in the rest home are large doubles, but are used to accommodate one person. Rooms are personalised with furnishings, photos and other personal items displayed.<br><br>There is space to store mobility aids, walking frames, hoists and wheel chairs. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities.  The dining and lounge areas are spacious and enable easy access for residents and staff.  Residents are able to access areas for privacy, if required.  Furniture is appropriate to the setting and resident needs.  It is arranged in a manner which enables residents to mobilise freely. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being | PA Low | All laundry is undertaken on site in two separate laundry areas by both laundry and care staff. Resident's personal items are laundered on site or by family members if requested.  The laundry staff interviewed demonstrated a sound knowledge of the laundry processes, and care staff were seen to consistently handle soiled linen in accordance with procedure using suitable personal protective equipment.<br><br>There is a team of three cleaning staff who have received appropriate orientation and training |

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| provided. | | Cleaning trolleys are not left unattended when in use and bulk chemicals are stored securely. A small number of chemicals are in use and were seen in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme. There are examples of cross contamination in the cleaning processes used. |
| | | Kitchen hands are responsible for cleaning in the kitchen. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are polices and guidelines for emergency planning, preparation and response. Disaster planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency.   The current fire evacuation plan was approved by the New Zealand Fire Service in November 2006.  A planned trial evacuation takes place six-monthly with a copy of completion sent to the New Zealand Fire Service, the most recent being on 30 June 2016. Trial evacuations take place on all shifts to ensure staff remain familiar with the required procedures. The orientation programme includes fire training and update quizzes are used on a regular basis to help maintain staff competency.   This is confirmed in the staff education records sighted. Staff confirmed their awareness of the emergency procedures. |
| | | A civil defence plan is in place.  There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones, torches, disposable items and gas BBQ's. Water containers are regularly refreshed.  A generator is available on site. Emergency lighting is regularly tested. |
| | | Registered nurses hold a current first aid certificate and several senior care staff also have current certificates.  Rosters sighted indicate that there is a competent first aider within the building on every shift.  First Aid Certificate records sighted show all staff who are required to have these hold a current certificate or are booked for early August training. |
| | | Call bells alert staff to resident's requiring assistance.  Visual call board displays are situated in the nurses' stations and corridors.  The call system is tested regularly by maintenance personnel. |
| | | Appropriate security arrangements are in place. Doors are locked as part of the security in the secure dementia facility and windows are locked by staff at a predetermined time each day. Camera surveillance of hallways and communal areas is undertaken. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with | FA | All residents' rooms and communal areas have opening external windows.  External access to secure garden or courtyard areas is through lounge areas. Shade is available. Electric heating is provided in all rooms, bathrooms hallways and communal areas. All areas are well ventilated with large windows |

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| adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | | that ensure adequate natural light throughout the facility. |
| Standard 3.1: Infection control management<br><br>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. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme (IPC). Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from an external consultant. The infection control programme and manual are reviewed annually, with the 2016 programme under review to incorporate any changes required following a recent infection outbreak.<br><br>The assistant clinical leader is the designated IPC coordinator. Infection control matters, including surveillance results, are reported monthly to the facility manager, discussed at the management meetings, and tabled at the registered nurse and staff meetings. A standalone IPC committee is under development as part of the programme review. Results of the surveillance programme are shared with staff via regular staff meetings. There is a current job description for the IPC coordinator role with clearly defined lines of responsibility.<br><br>Signage was used at the main entrance to the facility at the time of the outbreak to alert visitors that the facility was in 'lockdown'. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell, as occurred during the outbreak. |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control coordinator has been in the role since late 2015. She has sought suitable training through a local polytechnic, which has now been completed. She has attended a study session provided by a clinical microbiologist in April 2016. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory has been utilised for additional support/information is required. The IPC coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.<br><br>Personal protective equipment (PPE) was observed to be freely available to staff. The service also maintains a supply of additional equipment in case of an infection outbreak (supplies sighted). Staff confirmed the availability of sufficient PPE. |
| Standard 3.3: Policies and procedures | FA | The infection prevention and control policy reflects the requirements of the infection prevention and control standard (NZS 8134.3:2008) and current accepted good practice. Policies have been reviewed |

| 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. | | and include appropriate current referencing.<br><br>Care delivery staff were observed following organisational practices such as appropriate use of hand-sanitisers and use of disposable aprons and gloves.  Housekeeping staff were aware of generalised infection control practices.  Hand washing and sanitiser dispensers are readily available around the facility.  Staff interviewed verified knowledge of infection control policies and practices. |
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| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education and completed competencies in infection prevention and control at orientation and in ongoing education sessions.  Education is provided by suitably qualified registered nurses, and the infection control coordinator.  Content of the training is documented and evaluated to ensure it is relevant and understood.  A record of attendance is maintained.  Audits and competencies are undertaken to assess that standards are maintained.<br><br>When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  An example occurred following a recent norovirus outbreak, after which there was a general staff session presented on outbreak management provided by a microbiologist.  This was additional to the regular hand hygiene sessions as part of ongoing education.  One-to-one resident education within the context of a dementia facility focuses on reminders about handwashing. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance of a range of infections is undertaken.  The data collected is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory proven results.  These include urinary tract, soft tissue, fungal, eyes, gastro-intestinal, upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented on the infection reporting form and in the clinical record. More recently, data is being entered into an electronic system to enable trending, analysis and provides benchmarking opportunities. The infection control coordinator reviews all reported infections.  Data is collated and analysed monthly, and reported to the facility manager and the management and registered nurse meeting using graphs and raw data.  Any significant trends, possible causative factors and required actions are identified and actioned.<br><br>A summary report of the investigation for the recent gastrointestinal infection outbreak is still to be |

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| | | undertaken and learnings incorporated. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | There is a suite of policies that cover the requirements of the standard in relation to restraint minimisation. The differences between a restraint and enabler are described as are guidelines for de-escalation and note that use of an enabler is voluntary. There are not currently any enablers in use in this facility.<br><br>The clinical manager and the team leader of the rest home noted the reluctance of this service to use any form of restraint. It was reported as only being used as a last resort and when all other avenues for intervention had been explored. This was evident in client records. Staff informed that they are educated on restraint minimisation and expressed that it is only used for safety purposes. |
| Standard 2.2.1: Restraint approval and processes<br><br>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. | FA | A restraint committee, led by a restraint coordinator, meets every six months and meetings are minuted. The committee reports to the management team for quality improvement purposes. The committee reviews all restraint use and ensures the required documentation has been completed and that ongoing monitoring is occurring.<br><br>Approved restraints are bed sides (as a restraint), waist belts around the resident and chair, which is intended for use where a resident may attempt to move from a chair without assistance of staff or mobility aids, and the risk of injury is high, and lazy boy, fall/out chair. Environmental restraint as it relates to dementia care residential facilities to ensure a secure environment is defined within the restraint policy and has been signed off by management. |
| Standard 2.2.2: Assessment<br><br>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The organisational policy statement that restraint is used as a last resort was reinforced by the restraint coordinator. Staff informed that two hospital level care residents have been assessed as requiring restraint to keep them safe. The files of these residents were reviewed and both have had an assessment for restraint use that covers each aspect of (a) to (h) below. Both have been signed off and consented by EPOAs and the GP as required. A lap belt was identified as the most suitable form of restraint for both residents. One person was observed to be safely using their lap belt for restraint purposes on one of the days of audit. |
| Standard 2.2.3: Safe Restraint Use | FA | Alternative strategies from restraint are suggested in the records of both residents for whom restraint has been approved. Instructions include the need for support workers to seek permission from a |

| Services use restraint safely | | registered nurse prior to the use of restraint. The registered nurse assesses the viability of its use at that time and ensures staff are in the environment to monitor its use. |
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| | | Detailed instructions for use of the restraints and for managing challenging behaviours are documented in the respective resident's records. Restraint use monitoring recording is being completed and progress reports include comment on its use. |
| | | A restraint register was sighted and includes details of those for whom a restraint has been approved, the purpose of the restraint, the type of restraint to be used and the dates of approval and review. The register is reviewed six monthly. |
| Standard 2.2.4: Evaluation<br><br>Services evaluate all episodes of restraint. | FA | Registered nurses oversee the use of any restraint. Restraint use monitoring records are reviewed by the clinical manager/restraint coordinator and the approval for individual restraint use is reviewed at their three monthly reviews. The restraint coordinator reported that improved use of the monitoring records had occurred following education. Although not identified as a consistent problem, it was noted there were still some gaps in the documentation of when food and fluid had been provided. Times for applying and release of restraints were consistently documented and met policy requirements.<br><br>Overall evaluation of the ongoing use of restraints is being completed at the three and six monthly resident's review timeframes with restraint committee reviews six monthly. All aspects of (a) to (k) of this standard are being covered. Timeframes for restraint use are reviewed as part of these processes to ensure the residents involved, and in one case those around them, remain safe. |
| Standard 2.2.5: Restraint Monitoring and Quality Review<br><br>Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator provides a restraint management report, which includes the extent of restraint use, any change in its use, information about ongoing approval and reporting and any shortfalls in the monitoring records, to the facility and general manager of the facility every six months following the restraint committee meeting. The report is discussed at the management team meeting for quality improvement purposes, especially for opportunities for improving staff education and for any recommendations for changes in the related policy and procedure documentation. |

# 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) |
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| Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Moderate | A formal complaint about food was lodged in November 2015. Earlier in 2016 relatives of residents raised concerns about the quality and quantity of food being served to residents. This was identified in the results of a survey sent to relatives and was further discussed at a relatives' meeting in May 2016. A quality improvement plan was developed by the management team to address the concerns. The plan is comprehensive and has involved further surveys, a menu audit questionnaire, conversations with the cook, consultations with a dietitian, monitoring prepared food on a weekly basis and the establishment of a relative working group. Meals are being prepared according to the menu; however the standard of cooking and of presentation is not consistent with the level expected in an aged residential care facility. Relatives are still reporting that although there have been some improvements and weekend meals are fine, most meals are still not as good as expected and the meals served on the two days of audit verified their concerns. They were of very poor | Feedback, observation and complaints records do not consistently demonstrate that food, fluid and nutrition of residents are being provided according to recognised nutritional guidelines. In spite of an ongoing quality improvement project to address this, issues of concern persist. | Food and fluids are prepared in a manner that ensures nutritional value is maintained and they are provided in a manner that is appetising to ensure the nutritional needs of the residents are consistently met. |

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| | | presentation, markedly overcooked food, inadequately mixed, and sloppy and/or heavy consistency. There is evidence of weight loss in the weight monitoring records reviewed. When this was picked up in the quality improvement project the service provider introduced a range of measures, including notification to GP for weight loss. The quality initiative is due to be evaluated in September/October 2016.<br><br>There are high risks associated with residents not receiving nutritional meals. The risk is mitigated by the implementation of the quality improvement project and the ongoing monitoring, therefore this corrective action has been rated moderate, rather than high risk. | | 30 days |
| Criterion 1.3.13.5<br><br>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Moderate | Temperatures of chilled foods are not being checked on arrival, despite a section on a form having room for records of this. Temperatures of hot foods are being recorded daily, as are fridge and chiller temperatures; however there is no evidence that actions are being taken when they do not meet the expected temperature. There were no leftovers in the fridge and the kitchen staff reported that they are not kept beyond 24 hours. Not all foods had expiry dates on them, not all food containers are sealable, baking goods are being stored in plastic bins on the floor and areas of the kitchen were not as clean, or well-maintained as expected therefore compromising food safety (refer criterion 1.4.2.4). | Aspects of food delivery, storage and preparation do not comply with current guidelines. For example, there were inconsistent acceptable recordings of food delivery and serving temperatures, expiry dates were not included on all open food items, many food containers were unable to be sealed and bulk food is being stored on the floor. | Food production, preparation, storage and delivery will comply with current legislation and guidelines.<br><br><br>60 days |
| Criterion 1.4.2.4<br><br>The physical environment minimises risk of harm, promotes safe mobility, aids independence | PA Low | A number of aspects of the physical environment compromise infection control management in the facility.<br><br>Examples noted include:<br><br>1.        Shared bathrooms for rest home residents have deteriorating wall surfaces and cabinetry, leaving underlying wall linings and surfaces exposed.  This does not ensure adequate cleaning can occur or that infection control can be maintained. The owner reports that this is the | The physical environment is compromised in the rest home communal bathroom, hospital laundry and kitchen and does not ensure that infection control can be maintained. | Action is taken in those areas identified to ensure that infection control can be maintained in the facility. |

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| and is appropriate to the needs of the consumer/group. | | next area of the facility scheduled for an upgrade.<br><br>2.    The hospital laundry area does not facilitate a dirty/clean flow, with cross contamination occurring. Clutter, difficult to clean areas, damaged surfaces and general wear and tear contribute to a compromised environment.<br><br>3.    Aspects of the kitchen environment do not ensure infection control/food safety is maintained. | | 180 days |
| Criterion 1.4.6.2<br><br>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness. | PA Low | Although cleaning and laundry monitoring is occurring, this does not include that the cleaning processes are being undertaken in a manner that reduces the risks of cross contamination.  Observation of cleaning activity and interviews with cleaning staff demonstrated some inconsistent practice is occurring in the facility.  Cross contamination is occurring on the cleaning trolleys and in the cleaning practice. Areas of the kitchen, especially in corners, show evidence of accumulated food that have been missed in the cleaning processes. | Current cleaning practices are resulting in cross contamination, increased infection risks and the potential to compromise food safety. | Ensure cleaning practices meet the good practice cleaning standards, maintain infection control and ensure food safety.<br><br><br>180 days |

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

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| Criterion 1.3.8.2<br><br>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress | CI | Commencing with progress reports, no matter who has documented them these are peer reviewed by registered nurses each shift, including the night shift. At a minimum, the clinical manager reviews all progress reports, and any changes of care plans, on a weekly basis.<br><br>Any deviation from the expected is further reviewed and where necessary a short term care plan is developed if this has not already occurred. Short term care plans and wound care plans are mostly being reviewed daily and updates are consistently documented. After one week the effectiveness of the interventions is evaluated and if the problem persists it is transferred to the long term care plan. Residents' weights are monitored monthly and any deviation of two or more kilograms is followed up and investigated with pro-active interventions implemented if indicated. As noted in Standard 1.3.7, activity plans are reviewed three monthly with reports | Senior staff committed to improving evaluation and review processes. A planned approach to address this was developed and included staff education, reminders and increased and improved ongoing monitoring. The outcome of the monitoring and a review of the results have shown anticipated and non-anticipated outcomes, which are enhancing the care and support of residents. New problems and changes for residents are being identified earlier, the reporting is more consistent, other disciplines are being involved more promptly when this is advantageous and changes are being made to care plans when needed, rather than just at predetermined times. Evaluation and review of residents' care and associated documentation are occurring at a level of continuous improvement with an unanticipated additional advancement being that caregivers are now more actively involved with increased vigilance, earlier and more |

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| towards meeting the desired outcome. | | summarising the resident's level of participation and responses. Evidence of decreased motivation is followed up in the wider review.<br><br>Long term care plans are consistently reviewed on a three-month basis. Full multidisciplinary reviews of the care plans and activity plans for each resident that also include a medical review, family members and a review of the interRAI are in place according to a printed calendar schedule are occurring at six monthly intervals. There were no overdue reviews or evaluations in the residents' files reviewed. Modifications are made to care plan interventions when required and are dated accordingly.<br><br>The clinical manager and facility manager had identified evaluation and review of all aspects of care as an area for quality improvement. They then identified each point of evaluation and review and discussed which areas were not meeting the expected level. Attention was paid to best practice and this was promoted through staff education and reminders. The clinical manager has since been undertaking ongoing monitoring and checking of these processes, in addition to the routine internal audit process. The commitment to change has reportedly resulted in more comprehensive evaluation and review reports. The clinical and facility managers also reported that the improved processes are resulting in increased benefits for the residents. According to staff reports and documentation sighted the results show that early interventions are occurring, options for intervention are being discussed more openly and multidisciplinary intervention is being implemented more frequently.<br><br>Caregivers are documenting progress reports and are included in the residents' review processes. Although not measured to date, they reported they enjoy being part of these aspects of the service. Senior staff have also reported that since the increased involvement of caregivers they have become even more vigilant about watching for changes and more willing to report what they find to a registered nurse earlier. External health professionals were especially positive | comprehensive reporting. |

| | | about timely reporting of changes for residents, the good oversight of residents by registered nurses and the comprehensive reporting processes within this service. | |

End of the report.