# Rosebank Residential Limited - Rosebank Home 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Rosebank Residential Limited

**Premises audited:** Rosebank Home and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 1 May 2017 End date: 2 May 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 68

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | 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

Rosebank Home and Hospital provides care for up to 100 residents requiring rest home or hospital level care. On the day of the audit there were 68 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident’s and staff files, observations and interviews with residents, general practitioner (GP), relatives, staff and management.

Residents and families interviewed were very complimentary of the care and support provided. The general manager and clinical manager are well qualified for their roles.

This audit identified that improvements are required around: incident reporting; completion of clinical assessments; care planning; and restraint monitoring.

The service has achieved a continuous improvement rating around infection prevention and control.

## 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. |  | Standards applicable to this service fully attained. |

Rosebank Home and Hospital provides care in a way that focuses on the individual resident. Cultural and spiritual assessments are undertaken on admission and during the review processes. Policies are implemented to support individual rights such as: privacy; dignity; abuse/neglect; culture; values and beliefs; complaints; advocacy; and informed consent. Information about the Code of Health and Disability Services Consumers' Rights (the Code) and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Rosebank Home and Hospital has a quality and risk management system that supports the provision of clinical care. Quality data is collated for: accident/incidents; infection control; internal audits; concerns and complaints; and surveys. Incidents and accidents are documented.

There are human resources policies including: recruitment; job descriptions; selection; orientation; and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme in place. This includes training packages for all levels of nursing staff. External training is supported. There is a staffing policy and rosters in place.

## Continuum of service delivery

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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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Pre-admission information is made available to prospective residents and their families. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The electronic medicine charts reviewed meet prescribing requirements and are reviewed at least three-monthly.

A diversional therapist oversees and coordinates the activity programme with the assistance of a recreational officer and group of volunteers. The programme includes: community visitors; outings; entertainment; and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the rest home and hospital level of care residents.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met.

## Safe and appropriate environment

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

There are documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with access to ensuites or communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is at least one staff member on duty with a current first aid certificate.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently two hospital level residents requiring restraints and one resident using an enabler. Staff are trained in restraint minimisation and challenging behaviour management.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 46 | 0 | 1 | 3 | 0 | 0 |
| **Criteria** | 1 | 96 | 0 | 1 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with eleven care staff (six caregivers, four registered nurses (RN) and one diversional therapist) confirms their understanding of the Code. Seven residents (five rest home and two hospital level) and seven relatives (three rest home and four hospital level) interviewed confirm that staff respect privacy and support residents in making choices. |
| Standard 1.1.10: Informed Consent  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 | There are established informed consent policies/procedures and advanced directives. General consents are obtained as part of the admission agreement and are documented in eight long-term resident files reviewed. Advance directives include the resident’s resuscitation wishes. Copies of enduring power of attorney are on file as required. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.  Seven relatives (three rest home and four hospital) and residents (five rest home and two hospital) interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed confirm they are aware of their right to access independent advocacy services. Discussions with relatives confirms the service provides opportunities for the family/EPOA to be involved in decisions. The resident files include information on resident’s family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirm open visiting hours. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints policy and procedures are implemented. Complaint forms are available. Residents and family interviewed confirm they received information on the complaints process on admission and the care lead is very approachable should they have any concerns/complaints. Care staff are aware of the complaints process and to whom they should direct complaints.  A complaints folder is maintained. There were seven complaints received in 2016 and three made in 2017 year to date. All of the complaints documentation includes follow-up letters, investigations and resolutions and have been completed within the required timeframes. Corrective actions have been implemented as needed. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack given to prospective residents and families, which includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives confirm that information is provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The clinical manager or RN discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirms there are areas that support personal privacy for residents. Staff are respectful of residents’ privacy and knock on doors prior to entering resident rooms. Staff are able to describe definitions around abuse and neglect that align with policy. Relatives interviewed confirm that staff treat residents with respect. The service philosophy promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Caregivers described how choice is incorporated into resident care. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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 | The Māori health plan policy for the service references local Māori healthcare providers and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. At the time of the audit, there were no residents that identified as Māori living at the facility. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents and relatives interviewed report that they are satisfied that their cultural and individual values are being met.  Information gathered during assessment including resident’s cultural beliefs and values, is used to develop a care plan which the resident (if appropriate) and/or their family/whānau are asked to consult on. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. The staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers (general manager and clinical manager) and care staff confirms their awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the Health and Disability Services Standards to meet the needs of residents requiring rest home and hospital level of care. Staffing policies include the recruitment process, the requirement to attend orientation and participate in ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed demonstrate a sound understanding of principles of aged care and state that they feel supported by the management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when completing an incident/accident/near miss form. Twenty incident/accident/near miss reports reviewed met this requirement. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Rosebank Home and Hospital is privately owned and governed by a Board. The service provides care for up to 100 residents at hospital or rest home level care. On the day of the audit, there were 68 residents (24 hospital level care residents and 44 rest home level care residents- including 2 respite care residents). The service has 20 dual purpose beds in the rest home (adjacent to the hospital wing); 10 of which are occupied by residents requiring hospital level care.  An experienced general manager, who has been in the role for over ten years, manages the service. The general manager reports monthly to the Board on a variety of management issues. The current strategic plan and quality and risk management plans are being implemented. The general manager receives support from a clinical manager, education coordinator, quality/health and safety/infection control coordinator, registered nurses and care staff. Building and refurbishment work has been completed since the last audit to enlarge, refurbish and add ensuites to 16 rooms in the rest home wing. The service is planning to refurbish more rooms in 2017. |
| 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 | In the absence of the facility manager, the clinical manager is in charge with support from the management team and care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan is in place which includes key performance indicators (KPIs) around clinical quality. The business plan has additional financial KPIs. There are polices and procedure in place.  Monitoring of the quality and risk plan is through a series of meetings and reports. This includes a monthly report by the general manager to the Board, including copies of the monthly registered nurse and monthly quality meetings.  Meetings include: quarterly staff meetings; monthly registered nurse; and monthly quality meetings. All meetings document discussion and follow-up of: quality data; incidents and accidents; health and safety; infection control; complaints (where they occur); and restraint (as needed).  A series of quality improvement plans have been implemented around: new care plan templates; continence care; pressure injury prevention; falls prevention; pain management; and the roll-out of electronic medication management software.  The service completes internal audits as per the annual audit programme. Areas of non-compliance identified through quality activities are actioned for improvement.  Staff complete hazard identification forms for identified/potential hazards. A current hazard register is in place.  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service contracts a physiotherapist two days per week and a mobility assessor is employed three days per week.  Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The resident satisfaction survey 2016 reported 100% overall satisfaction with the service. |
| 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. | PA Moderate | There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. There is discussion of incidents/accidents/near misses at monthly quality and quarterly staff meetings including actions to minimise recurrence. Twenty incident forms sampled document that clinical follow up of residents is conducted by a registered nurse. However, neurological observations are not consistently documented for unwitnessed falls. Discussions with the general manager and clinical manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications made since the previous audit includes notification of a pressure injury and sudden death of a resident. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. Job descriptions are available for all relevant positions. Practising certificates reviewed are current. Eight staff files were reviewed (the clinical manager, one housekeeper, one diversional therapist, two caregivers, one head cook and two RNs). Evidence of signed employment contracts, job descriptions, orientation and training, are included in the files reviewed. Annual performance appraisals have been conducted for all staff as they fall due. Newly appointed staff complete an orientation that is specific to their job description. Care staff interviewed confirm that orientation programme includes a period of supervision. The service has filmed an infection control DVD as a quality improvement initiative in response to learning opportunities from an outbreak which occurred in 2014. This DVD is used for infection control training at orientation of new staff (link to 3.5.1).  The service has an annual training schedule for in-service education which is developed by the education coordinator. External training is available for RNs. Education has been provided and attendance recorded. Staff complete competencies relevant to their roles. Registered nurses are trained and competent in the use of the interRAI assessment tool. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policies include staff rationale and skill mix.  There is a RN rostered on duty on each shift over seven days per week in the hospital.  There are 20 dual purpose beds in the rest home (adjacent to the hospital wing); 10 of which are occupied by hospital level care residents.  A RN is rostered on duty on the morning shift Monday-Friday in the rest home. The RN on duty in the hospital on afternoon and night shift provides oversight of the hospital residents in the rest home and support to the senior caregiver.  There is also a clinical manager who works 6.5 hours daily Monday to Friday and an occupational health and safety/wound care advisor (RN), works three days per week.  There are sufficient caregivers rostered on duty each day to support the RNs and meet the needs of residents.  Staff are visible and attend to call bells in a timely manner as confirmed by all residents interviewed. Staff state that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record with the exception of one rest home respite resident (link to 1.3.4.2). Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or RN. Individual resident files demonstrate service integration. This includes medical care interventions and records of the diversional therapist. Medication charts are stored electronically on the medication management programme in use. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. The service has a comprehensive information folder for residents/families/whānau at entry. Eight admission agreements for long-term residents align with all contractual requirements. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs and senior caregivers) have been assessed for medication competency on an annual basis. RNs have completed syringe driver training. Education around safe medication administration has been provided. Robotic roll medications are checked on delivery by the RN. ‘As required’ medication expiry dates are checked regularly. Standing orders are not used. No residents were self-medicating on the day of audit. Medication fridge temperatures are checked and recorded weekly.  All 18 medication charts reviewed on the electronic medication system meet legislative prescribing requirements. The GP has reviewed the medication charts three-monthly. All medications have been administered as prescribed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Rosebank are prepared and cooked on-site by a qualified cook and kitchen assistants. A food supervisor oversees the service. There is a four-week seasonal menu which has been reviewed by a dietitian (March 2017).  Meals are kept hot in a bain marie until serving commences. Meals are covered with insulated lids and delivered from the rest home to the hospital dining room and resident rooms. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements and food dislikes are accommodated. Additional or modified foods are also provided by the service. Specialised plates and utensils are available for residents as assessed.  Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are taken on the main meal. The dishwasher is checked regularly by the chemical supplier. Food items sighted are date labelled. All food services staff have completed training in food safety and chemical safety.  Nutrition and safe food management policies define the requirements for all aspects of food safety. A kitchen cleaning schedule is in place and implemented. Containers of food are labelled and dated.  Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. |
| Standard 1.3.2: Declining Referral/Entry To Services  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 | There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate, if entry was declined. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The RN completes an initial assessment on admission and a range of risk assessment tools for long-term residents, however there was no admission assessment for the respite care resident. An interRAI assessment is undertaken within 21 days of admission, however the interRAI assessment has not always been completed six-monthly. Resident needs and supports are identified through the ongoing paper based assessments and form the basis of the care plan. Risk assessment management plans are in place for falls risk and pressure injury risk. There was no pain assessment for one resident with acute pain. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident care plans are resident focused and individualised. Not all support needs are included in the long-term care plans for three residents with weight loss and two care plans did not reflect the resident’s current skin integrity. Care plans evidence resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirm they were involved in the care planning process.  Resident files demonstrate service integration. There is evidence of allied health care professionals involved in the care of the resident including mobility assessor, physiotherapist, podiatrist and dietitian. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the RN initiates a review and if required, a GP, dietitian or nurse specialist consultation. There is evidence that family members are notified of any changes to their relative’s health including (but not limited to): accident/incidents; infections; health professional visits; and changes in medications. Discussions with families and notifications are documented in the resident files sampled.  Adequate dressing supplies are available in the treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations are in place for eight residents with wounds. There is a range of equipment readily available to minimise pressure injury. The service has a wound care advisor/RN who is on-site three days a week and reviews the wounds at least weekly. There was evidence of district nursing involvement where required.  Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.  Monitoring occurs for: weight; baseline observations; blood glucose; and challenging behaviour.  Short-term care plans document appropriate interventions to manage short term changes in health. |
| Standard 1.3.7: Planned Activities  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 service has a qualified registered diversional therapist (DT) who is involved in regional DT meetings and networking. The DT is employed 33.5 hours a week, Monday to Friday. A recreational officer is employed from Tuesday to Saturday. The activity programme is flexible and provides activities to meet the residents’ cognitive and physical abilities. The service has 19 volunteers involved in assisting the activity team and are involved in one-on-one activities, card games and church services.  Interactive theme days involve residents and staff such as the “SS Rosebank” which included a cruise theme. The service has introduced more variety in games and smaller more frequent group outings. The service hires a bus or wheelchair taxi for outings including the weekly visit to the RSA. There are many community visitors, speakers, entertainers, church groups, pre-school children and Kapa Haka group. Church services are held weekly.  An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate). Activity plans in all files are reviewed six-monthly.  Resident meetings are held three-monthly. The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed had been evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans. Evaluations indicate if the resident goals have been met or unmet. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.  There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  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 to ensure incidents are reported in a timely manner. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas and safety datasheets are readily available for staff. A spills kit is available. Personal protective clothing is available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 1 July 2017. The building is two levels with staff only areas on the first floor and all resident rooms on the ground floor. Sixteen resident rooms have been refurbished to include ensuites.  Rosebank employs a full-time maintenance person. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed by an external contractor two-yearly. Annual calibration and functional checks of medical equipment is completed by an external contractor.  Hot water temperatures in resident areas are monitored. Temperature recordings reviewed are below 45 degrees Celsius and corrective actions documented where required.  The facility has wide corridors with rails and sufficient space for residents to safely mobilise using mobility aids.  There is safe access to the outdoor areas. Seating and shade is provided.  The care staff and RNs interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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 | Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are both ensuite bedrooms and communal toilet/shower facilities. Communal toilet facilities have a system that indicates if it is engaged or vacant. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All rooms are single. There is adequate room to safely manoeuvre mobility aids (in rest home rooms) and transferring equipment such as hoists in the resident dual purpose and hospital level rooms. Residents and families are encouraged to personalise their rooms. This was evident during a tour of the facility. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas within the facility include a lounge and dining area in each unit along with additional smaller lounges and seating alcoves. Seating and space is arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry staff seven days a week. Residents and family interviewed report satisfaction with the cleaning and laundry service. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes. Staff have completed chemical safety training. The cleaning trolley is stored in a locked room when not in use. There is personal protective equipment readily available in the two sluice rooms and on cleaning trolleys. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short term back-up power for emergency lighting is in place.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is on duty at all times.  There are call bells in the residents’ rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows which are designed and installed to promote ventilation.  The residents and family interviewed confirm the internal temperatures are comfortable. |
| Standard 3.1: Infection control management  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 infection control coordinator is a registered nurse (also the wound care advisor and OSH coordinator). The infection control coordinator is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to the combined Infection Control and Health and Safety Committee meeting.  The 2016 infection control programme has been reviewed and is linked to the quality system.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine. This year, 58 of 68 staff have had the influenza vaccine. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The RN infection control coordinator has attended wound care conferences and receives monthly infection control journals. The combined Infection Control/Health and Safety Committee are representative of all services and meet two-monthly.  The infection control coordinator has access to GPs, local laboratory and microbiologist, the infection control nurse specialist and public health departments at the local DHB for advice and an external infection control consultant specialist. |
| Standard 3.3: Policies and procedures  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. | FA | The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external consultant and aligned with Rosebank’s facility specific policies and procedures, which are reviewed regularly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and are ongoing. Staff complete infection control quizzes.  Resident education is expected to occur as part of providing daily cares, as appropriate. Infection control is discussed at resident meetings. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff on the infection control noticeboard in the staff office. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the quality improvement and Health and Safety/Infection Control Committee meetings. Annual infection control reports are provided. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. Systems in place are appropriate to the size and complexity of the facility.  There has been one outbreak in September 2016 which was managed well by implementing the improvement tools and practice resulting from an outbreak in 2014. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure that the use of restraint is actively minimized. There are two residents with restraint and one resident with an enabler. Enabler use is voluntary. All necessary assessments and evaluations have been completed in relation to the restraints. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality and staff meetings. The clinical manager is the designated restraint coordinator. |
| Standard 2.2.1: Restraint approval and processes  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 | The clinical manager is the restraint coordinator. Assessment and approval process for restraint use includes the restraint coordinator, RNs, resident/or representative and medical practitioner. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are completed by a RN in partnership with the family/whanau, in the two files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the two restraint files and one enabler file reviewed, assessments and consents are fully completed. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified through the assessment and approval processes. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed have a completed assessment form and a care plan that reflects risk. Monitoring forms that did not always include regular half hourly monitoring, were present in the files reviewed. The service has a restraint and enablers register which was up to date. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every six months. In the restraint files reviewed, evaluations had been completed with the resident, family/whanau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at RN/clinical meetings and quality meetings. Evaluation timeframes are determined by policy and risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly RN/clinical meetings and quality meetings. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Individual incident reports are completed for each incident/accident/near miss with immediate action noted. The data is linked to the quality programme and this is used for comparative purposes. Minutes of the staff meetings reflect a discussion of results. Six of ten incident reports for unwitnessed falls document that neurological observations have been fully completed as per policy. | Four of ten incident forms sampled, where the resident had experienced an unwitnessed fall, do not document that neurological observations have been completed as per policy. | Ensure that neurological observations are recorded for unwitnessed falls as per policy.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Initial interRAI assessments have been completed within the required timeframe. Six-monthly paper based assessments are completed routinely for all residents and link to the care plan. Shortfalls are identified around the completion of interRAI assessments six-monthly in conjunction with the care plan evaluation, initial assessment for the respite care resident and a pain assessment for one resident with acute pain. | i) There was no initial assessment of baseline observations including weight, pain assessment or skin/pressure injury risk assessment completed for the rest home respite care resident.  ii) The interRAI six-monthly assessments have been completed but not within six months for five of eight long-term files reviewed (three rest home and two hospital residents).  iii) One rest home resident did not have an assessment completed for identified acute pain requiring medical intervention. | i) Ensure initial assessments are completed for respite care residents.  ii) Ensure interRAI assessments are completed six-monthly as part of the care plan evaluation process.  iii) Ensure pain assessments are completed for residents who identify with pain.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Six of nine care plans reflect the outcomes of the assessments and reflect the resident’s current health status. Three of eight long-term care plans do not reflect interventions to meet the residents needs/supports. | i) Two hospital residents’ care plans have not been updated to identify their pressure injuries have healed.  ii) Two hospital residents and one rest home resident do not have documented interventions for weight loss. | i-ii) Ensure care plans reflect the resident’s current health status.  60 days |
| Criterion 2.2.3.2  Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service providers or others; (b) Following appropriate planning and preparation; (c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation. | PA Low | The two restraint files sampled include monitoring requirements (both half-hourly) on the monitoring form and in the care plan. Monitoring forms are in place for both residents, but half-hourly monitoring is not always documented. | The two restraint monitoring forms sampled did not consistently document the required half-hourly monitoring. | Ensure restraint monitoring occurs within the designated timeframes and that this is documented.  90 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 3.5.1  The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation. | CI | The service has an Infection Control Committee that meets two-monthly.  Surveillance data is reviewed at this meeting and where required, corrective action plans are developed.  The Infection Control Committee undertook a post incident review following an outbreak in 2014 and identified an improvement was required around communication with families, residents and staff. | The service had an infectious outbreak (norovirus) in September 2016, which affected 55 residents and 6 staff. The appropriate notifications were made and the improved infectious outbreak protocol for communications was implemented which included: a) the use of an electronic database to keep all families informed; b) communication with all staff on and off duty on a daily basis; c) communication with all services including the development of a daily resident record; and d) daily fax communication with resident GPs regarding the health status of their patients. In addition, the infection control awareness and management of the outbreak was contained to three days. There were adequate resources available. A post debrief was held for staff and feedback sought from all staff including laundry, food services and caregivers. One of the cleaning staff was awarded the Health and Safety award of the year 2016 for her commitment to cleaning services. The staff member placed herself on the daily roster to provide consistency around cleaning services, including the thorough post outbreak full clean of the facility. A post outbreak staff survey validated the improvement made from the 2014 outbreak had made a positive improvement on the management of the 2016 outbreak. Families were especially appreciative of the improved communication channels and many letters of thanks were sighted. A further improvement from the 2016 outbreak, was the development of an infection control outbreak management video that staff view on orientation and ongoing. The video includes the correct application of personal protective equipment. |

End of the report.