

# Rosewood Resthome Limited - Rosewood Resthome and Hospital

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## Introduction

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

The audit has been conducted by 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:

**Legal entity:** Rosewood Resthome Limited

**Premises audited:** Rosewood Resthome and Hospital

**Services audited:** Hospital services - Psychogeriatric services; Dementia care

**Dates of audit:** Start date: 13 September 2017 End date: 13 September 2017

**Proposed changes to current services (if any):** Reconfiguration of 20 hospital services psychogeriatric beds to become 20 hospital services geriatric and hospital services medical

**Total beds occupied across all premises included in the audit on the first day of the audit:** 40

# Executive summary of the audit

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## Introduction

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

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

## General overview of the audit

Rosewood Rest Home and Hospital provides dementia rest home and hospital psychogeriatric level care for up to 64 residents. The service is operated by a private company and managed by a facility manager. The proposed change to the service is to reconfigure 20 hospital geriatric (psychogeriatric) beds to 20 hospital services geriatric and hospital services medical beds. The one family member interviewed with a resident in the wing spoke positively about the care provided and the proposed change.

This partial provisional 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 a family member, management and staff. At the time of the audit there were only three residents in the wing audited.

This audit has resulted in identified areas of improvements relating to training and emergency call bells. Improvements have been made to nutrition, the environment and cleaning processes addressing those areas requiring improvement at the previous audit.

## **Consumer rights**

A complaints register is maintained with complaints information entered within required timeframes.

## **Organisational management**

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

## **Continuum of service delivery**

Medicines are safely managed and administered by staff that are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## **Safe and appropriate environment**

The area audited meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff uses protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite/offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Family interviewed reported a timely staff response to call bells. Security is maintained.

## **Restraint minimisation and safe practice**

Not applicable to this audit.

## **Infection prevention and control**

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	14	0	2	0	0	0
<b>Criteria</b>	0	35	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints register reviewed showed that one Health and Disability Commissioner complaint was received in late August, and a response letter has been returned to the HDC. Timeframes for the initial response have been met.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the owners showed adequate information to monitor performance is reported including clinical indicators, occupancy, emerging risks, incidents, accidents and complaints.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for two years. She has previously been in the clinical leader position for four years at the facility. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending local and national seminars and courses.</p>

		<p>The service holds contracts with DHB, MoH for respite, hospital psychogeriatric (40 beds) and rest home dementia (24 beds) for a total of 64 residents. The proposed configuration will reduce the number of psychogeriatric beds from 40 to 20, and 20 beds will be reconfigured as hospital geriatric and hospital medical. The funders have been notified of the proposed changes. On the day of the audit there were 19 residents in rest home dementia and 21 residents in the psychogeriatric hospital service.</p> <p>The organisation has included the prospective service stream in the organisational structure with a pre-determined lead in time. Identified changes in key personnel have already been included in a staggered roster to ensure staffing remains above recommended guidelines.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the facility manager is absent, other members of the of the leadership team carry out all the required duties. The general manager, present during the audit, 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. Full time registered nurses are included from commencement of the new service, with care staff staggered to increase as resident numbers increase.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required, however there is no evidence that all the registered nurses have completed the Nursing Council of new Zealand (NCNZ) required Code of Conduct training. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including care staff mandatory</p>

		<p>training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments, although training relating to complex medical or critical conditions has not been completed. The facility manager reported she is preparing a training plan to manage these training requirements. Records reviewed demonstrated completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An after-hour on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. A family member interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven (24/7) days a week cover. There is a documented and planned increase of care, housekeeping and diversional therapy staff relating to the number of residents in the proposed service stream. An RN will be on duty in the proposed hospital wing 24/7.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided</p>

		<p>monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines.</p> <p>As this is a dementia care facility there are no residents who self-administer medications at the time of audit. A new policy has appropriate processes in place to ensure that if there are residents in the proposed service that do self-administer medications this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal now comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued 10 April 2016. Food temperatures, including for high risk items, are now monitored appropriately and recorded as part of the plan. The recently employed cook (Nov 2016) has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. There have been no complaints regarding the food service since the current cook has commenced. All previous required improvements have now been met.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets</p>

		<p>and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by a family interview, satisfaction surveys and resident meeting minutes, since the employment of the new cook. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required Chemical Handling Approved Handler Training (HSNO). An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 01 April 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted. At the time of the audit there were three residents in the wing where hospital geriatric and medical services are proposed'. No changes will be required to the environment to accommodate the change of service. The service has access to any additional medical equipment that maybe necessary.</p> <p>External areas are safely maintained and are appropriate to the resident groups</p>

		<p>and setting.</p> <p>One family member interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. Action has been taken in the communal bathroom, hospital laundry and kitchen to ensure that infection control can be maintained, addressing a previous required improvement.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the wing. This includes large toilet and shower ensembles between two rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. The three rooms in use are personalised with furnishings, photos and other personal items displayed. The door width and room size is adequate for the resident group, including access into the shared ensuite.</p> <p>There is room to store mobility aids and wheel chairs. Staff and the family member interviewed reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. The family member interviewed reported the laundry is managed well and the resident's clothes are returned in a timely manner.</p> <p>Chemicals were stored in a lockable cupboard and were in appropriately labelled</p>

		<p>containers. Cleaning trolleys were observed be locked away when not in use, and cleaning practices demonstrated good practice. These previous areas requiring improvement have been addressed.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in November 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 2 March 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. However, there is not a separate emergency call and this needs addressing.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto outside garden or small patio area. Heating is provided by electric heaters in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and the family member interviewed confirmed the wing is maintained at a comfortable temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from an external advisor. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager / registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager and facility manager, and tabled at the quality committee meeting. This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Continuing education is planned, including mandatory training requirements for care staff. Staff working in the dementia care area have either completed or are enrolled in the required education.</p> <p>Three registered nurses' personnel files were reviewed and all have current APCs, but there is no evidence that they have completed the Nursing Council of New Zealand Code of Conduct training. This was confirmed at interview.</p> <p>All eight RNs have completed interRAI assessment training and training relevant to dementia care, but they have not completed training relating to complex medical or critical conditions. All RNs have commenced palliative care training and at the time of the audit have completed two of eight modules.</p> <p>The facility manager is preparing a training plan for RNs which will include complex conditions, wound</p>	<p>Current RNs have not completed training relating to the NCNZ Code of Conduct, complex medical and critical conditions, syringe drivers, PEG tube feeding and palliative care.</p>	<p>A training plan is developed and implemented to ensure all RNs complete the required and relevant training.</p> <p>Prior to occupancy days</p>

		management, critical conditions, syringe driver training, percutaneous endoscopic gastrostomy (PEG) feeding and advance directives, however this has not yet been completed.		
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	PA Low	<p>The facility has three separate wings. Two wings have upgraded call bells to include a regular call alert and a separate call for use in an emergency to summon assistance. In all wings, there are lights outside each room when a call bell rings, at each end of the hallway, and in the wings nurses' station. The third wing that will be reconfigured does not have the upgraded call system in place, and while there is a regular call bell, there is not a separate alert to use in an emergency.</p>	<p>The proposed wing's call bell system does not have a separate alert to identify if the call is an emergency.</p>	<p>The call bell system requires a separate alert from the regular call bell to identify if the situation is an emergency.</p> <p>Prior to occupancy days</p>

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

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

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

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

No data to display
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End of the report.