

Rosewood Resthome Limited - Rosewood Resthome and Hospital

Introduction

This report records the results of a Surveillance 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; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 27 February 2018 End date: 27 February 2018
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:	49

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Rosewood Rest Home and Hospital in suburban Christchurch provides rest home, hospital and psychogeriatric care for up to 66 residents. The service is privately owned and managed by a facility manager, with oversight from a general manager. Family members expressed full satisfaction with the level of care being provided in this facility.

This unannounced surveillance 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 resident, family members, management, staff and a general practitioner.

One area relating to staff education and competency reviews that impacted on annual performance appraisals was identified for corrective action. Four areas identified as requiring improvement at the previous certification audit and two areas from the interim partial provisional audit had been fully addressed.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The facility manager is responsible for the management of complaints and the wider complaints process. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

Rosewood Rest Home and Hospital is privately owned and is managed by a facility manager, with oversight from a general manager. A business and quality and risk management plans are documented and include the scope, direction, goals, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular weekly reporting by the facility manager to the general manager, who in turn reports to the director.

The facility manager is an experienced and suitably qualified manager who is a registered nurse. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. The system is supported by an electronic system, which aids in the collation and analysis of quality improvement data, which is benchmarked nationally. Discussion of trends and follow up where necessary is occurring at quality improvement and staff meetings. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Actual and potential risks are identified and mitigated, and the hazard register was up to date.

A suite of policies and procedures cover the necessary areas, were current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation is completed by new staff. Although attendances are low, a systematic approach to identify, plan, facilitate and record ongoing training is in place to support safe service deliver. Registered nurses undertake a comprehensive training plan.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of senior staff on call out of hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	---	--

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

Food services meet the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

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

The building warrant of fitness is current and although renovation has occurred, there has not been any reconstruction of the facility since the last audit activity.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

The organisation has a set of policies and procedures that support the minimisation of restraint. Restraint is only used as a last resort when all other options have been explored and there were no enablers or restraints in use at the time of the audit. In addition to training every two years, staff are required to complete an annual competency in relation to restraint and enabler use. Staff demonstrated a sound knowledge and understanding of the restraint and enabler use processes and of managing challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	18	0	0	1	0	0
Criteria	0	43	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints and compliments policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents' family members on admission and there is complaints information and forms available in the reception area and the offices within the facility.</p> <p>The complaints register reviewed showed that sixteen complaints have been received since August 2016 and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. Complaints are now being recorded both electronically and in hard copy.</p> <p>Complaints management and follow up is the responsibility of the facility manager, who openly informs complainants about advocacy services and the option to refer any issue to the Health and Disability Commissioner (HDC). One complaint that was reviewed by the Health and Disability Commissioner has been closed out with no further follow-up required, although the service provider has taken appropriate action to reduce the likelihood of a recurrence. A second is still under investigation and the latest correspondence from the HDC dated November 2017 states it has been referred to an independent assessor for further review. Meantime the facility manager has implemented training and staff reminders about expected standards around delivery and review of care.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures on open disclosure were sighted and meet the requirements of the Code. Staff understood the principles of open disclosure and informed they are required to sign they have read these documents. Family members stated they are kept well informed about any changes to their relative's status and are advised in a timely manner about any incidents or accidents. They also talked about their involvement in the care planning process and said that the outcomes of regular and any urgent medical reviews are discussed with them. This was supported in residents' records reviewed, in particular the family contact recording sheets, which are being consistently updated.</p> <p>Interpreter services are accessed using the contact details in the interpreter service policies and procedures. The facility manager was familiar with the process, although reported this had not been required in the years she had worked in this facility. All current residents are competent in speaking English. The interpreter policy also informs on communication with people who may be visually or hearing impaired.</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>	<p>FA</p>	<p>The strategic business plan, which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. Registered nurses provide a weekly report to the facility manager, who in turn develops a weekly report for the general manager. The general manager is responsible for reporting to the managing director. A sample of internal reports was reviewed and showed that adequate information to monitor performance is being reported including overviews of occupancy, staffing issues, service delivery performance, emerging risks and updates on issues of concern that have previously been identified.</p> <p>Rosewood Home and Hospital is managed by a facility manager, with oversight from a general manager based in Whanganui who was previously her mentor. The facility manager, who has been in the role for two and a half years, is suitably skilled and experienced. In addition to being a registered nurse with a current annual practising certificate, she has attended leadership and management courses and confirmed knowledge of the sector, regulatory and reporting requirements. She maintains currency through attendance at aged care sector conferences, seminars and training. Responsibilities and accountabilities of the facility manager are defined in a position description and individual employment agreement. Support from the general manager is ongoing with a minimum of weekly contact and the owner/managing director takes an active interest. A team of registered nurses work alongside the facility manager, three of whom are about to take on new roles of clinical care coordinators, one in each of the specialty areas of the rest home, hospital and psychogeriatric unit.</p> <p>The service holds contracts with the District Health Board for 26 rest home (dementia) beds; 20 aged care hospital level care beds; and 20 beds in the psychogeriatric unit, all of which sit under the Aged Related Residential Care Agreement contract. One person in the service is currently on a mental health contract (under 65 years of age).</p>
<p>Standard 1.2.3:</p>	<p>FA</p>	<p>The organisation has a quality assurance and risk management system that reflects the principles of continuous</p>

<p>Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>improvement and is understood by staff. This includes management of incidents and complaints, internal audit processes, a regular patient satisfaction survey, monitoring of outcomes and clinical incidents including infections, wounds, residents' weights and pressure injuries.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements and were current. These are provided by an external quality consultant who as part of the contract is responsible for ensuring documentation is current and meets the requirements of the document control system described in the documents. Staff are required to sign acknowledgement they have read any new or updated policy document.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs, and related information is reported and discussed at the quality improvement management team meetings and at the various staff meetings. Minutes reviewed included discussion on the above-mentioned topics, including environmental concerns. An internal audit monitoring system is being maintained according to a pre-determined annual schedule. Staff reported during interview their involvement in quality and risk activities through reading meeting minutes, active roles within the health and safety team, assisting with internal audits and completing forms such as incident reports. The last family survey was in 2016 with the next due this year. Concerns about food were raised and have since been addressed.</p> <p>The quality consultant provides access to an electronic recording and analysis system for the management of quality and risk issues. Related data is being entered, analysed and then benchmarked at a national level. This system is also enabling the corrective action system to be well managed with all on file being systematically updated and closed out within acceptable timeframes.</p> <p>The facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. A risk register shows consistent review and updating of risks, risk plans and the addition of new risks. Two staff from the health and safety team confirmed their awareness of the Health and Safety at Work Act (2015) requirements and described how some of these requirements are being implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected</p>	<p>FA</p>	<p>Policy and procedures describe essential notification reporting requirements for events varying from pressure injuries, health and safety incidents and accidents, human resources, infection control, the coroner and changes in management. The facility manager was able to quote all such instances when essential notification reporting would be required and informed that other than an outbreak of norovirus, there have not been any notifications of significant events since the previous audit.</p> <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Information from these forms is transferred into an electronic database where adverse event data is collated, graphed, analysed, discussed with the registered nurses and reported to the quality improvement meetings. Evidence of these actions was sighted in meeting minutes, which showed discussion in relation to trends,</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>action plans and improvements made.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Validation of qualifications and practising certificates, where required, are completed at the time of new staff recruitment and when any registered health professional becomes routinely responsible for an aspect of residents' care.</p> <p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes an application and initial interview process, referee checks and police vetting. Although the majority of staff have been employed for a number of years, the sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepares new staff well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed showed documentation of completed orientation.</p> <p>Staff reported they are supported to attend any external training they request. Mandatory training requirements are defined and scheduled to occur over the course of the year. 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. Access to ongoing training in dementia care is provided. All registered nurses had a comprehensive training plan on file, which were up to date. A training day had been provided to ensure the registered nurses meet the relevant training requirements. The records sighted confirmed the issues in relation to registered nurse training that were raised for corrective action at the partial provisional audit have been addressed.</p> <p>Continuing education, which includes mandatory topics, is planned on an annual basis, although staff education records showed that overall attendance is low. A system for the annual review of the competencies that are completed during orientation is also in place. An annual performance appraisal process is undertaken once staff complete the competencies, however not all were current.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents. Staff informed that they only need to inform the facility manager of any concerns around staffing levels and the situation will be reviewed.</p> <p>The minimum number of staff is provided during the night shift and consists of one registered nurse and three</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>caregivers spread across the facility. An afterhours on call person of a senior staff person is noted on the roster. Staff confirmed that there is always good access to additional advice and support when needed. Caregivers reported adequate staff are available and that they are able to complete the work allocated to them. While there is registered nurse cover over 24 hours on seven days a week, with at least three on duty each day, there is also a plan for staged registered nurse allocation in the hospital wing as resident numbers increase.</p> <p>Family members were extremely positive about the calibre of care and support provided at Rosewood Home and Hospital. Observations and review of a four-week roster cycle sampled during this audit confirmed adequate staff cover has been provided. Short notice roster gaps are covered by other staff not rostered for that day and on the two occasions over the past year when a caregiver was unavailable, the registered nurse took over the care role and the facility manager took over the registered nurse role. At least one staff member on duty has a current first aid certificate and is identifiable on the roster. Likewise, a senior person is identifiable on the roster for all three areas.</p> <p>There is a sufficient number of trained and competent registered nurses who are maintaining their annual competency requirements in the interRAI assessment system with six of the seven registered nurses having been trained in its use.</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 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 include 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 was consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p>

		<p>There were no residents who were self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<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 and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the dementia services have access to food and fluids to meet their nutritional needs at all times.</p> <p>Food services are undertaken by two cooks, one of whom works weekends only, and kitchen hands, in an on-site kitchen. A four week rotating menu is in place. To ensure the food follows recognised nutritional guidelines for older people, the menu was reviewed by a registered dietitian on 2 April 2016. An interim review was completed 21 October 2017 at the service provider's request, as a result of corrective actions raised at the certification audit. As residents are now receiving appetising food and fluids in a manner that also ensures nutritional value is maintained, the previously raised corrective action on this matter has been addressed.</p> <p>The service operates with an approved food safety plan and registration issued by Christchurch City Council, 2 February 2018. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal now comply with current legislation and guidelines, which means a corrective action raised at the certification audit has also been satisfactorily addressed. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan both at the time of transfer to the hot boxes and again just prior to serving. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed. Family members interviewed reported they are fully satisfied with the menu and the food provided with some noting the changes that have occurred.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	FA	<p>Click here to enter text</p>

manner.		
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very good standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by one trained diversional therapists holding the national Certificate in Diversional Therapy, and an activities person.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Families/whānau are involved in evaluating and improving the programme through family meetings, satisfaction surveys. Family interviewed confirmed they find the programme varied.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes a 24-hour plan for activities that staff can utilise.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, behaviour and mobility. When necessary, and for unresolved problems, long term care plans are added to an updated. One resident and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>The building has a current building warranty of fitness with an expiry date of 1 April 2018.</p> <p>The rest home shared bathroom, hospital laundry and kitchen has been renovated, which is enabling infection control to be more effectively maintained, addressing a previously raised corrective action at the certification audit.</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>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness as part of the internal audit process. Observations made and conversations with staff confirmed that attention to detail and the correct products and equipment are being used during cleaning processes. There was no evidence of practices likely to result in cross contamination. Renovation of the kitchen has also enabled easier and more effective cleaning in this area. The corrective action raised at the certification audit has been satisfactorily addressed.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Renovation of the hospital wing has included completion of the installation of the call bell system, which now includes a dual alert of a regular call bell and an emergency alarm in each room and area where a call bell is installed. A test of the system was undertaken during audit. The ability for staff to identify an emergency situation in the hospital area has addressed a corrective action raised during the partial provisional audit for the reconfiguration of services.</p>
<p>Standard 3.5:</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC</p>

<p>Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed on an electronic system to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager and quality meeting.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility manager is the current restraint coordinator who is responsible for overseeing the restraint minimisation system, as well as any enabler or restraint use. A restraint management committee is coordinated by the facility manager/restraint coordinator, meets twice yearly and includes health and safety representation.</p> <p>Staff confirmed they had received education on managing challenging behaviours, and on the use of any enabler or restraint, in 2017. This was confirmed in the training schedule. They also demonstrated a sound understanding of the organisation's policies, procedures and associated practice.</p> <p>A register of restraint use was sighted, which confirmed the restraint coordinator's report and staff confirmation that there are not currently any residents who require an enabler or a restraint. The main approved restraint used in the past has been a lap belt.</p> <p>It was evident during review of the quality improvement committee meetings minutes that restraint would only be used as a last resort when all alternatives have been explored.</p>

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>	<p>PA</p> <p>Moderate</p>	<p>There is a detailed training plan for registered nurses. Records sighted and reports provided confirmed that all registered nurses have completed these requirements. A wider annual staff training schedule has been developed, is current and is being implemented. Attendance records were sighted and demonstrate low attendance rates at all sessions, including those determined as mandatory training topics.</p> <p>In addition to staff being enrolled in the New Zealand Certificate in Health and Wellbeing, or having completed the equivalent, a system is in place whereby the orientation competencies are required to be completed prior to each staff person’s annual performance appraisals. The facility manager informed that the competencies have been distributed to staff and examples of returns were sighted. However, the master list of staff and their progress with completed competencies and their subsequent performance appraisals demonstrated that more than 50% are overdue with some staff not having had their competencies reviewed since late 2015, or early</p>	<p>An annual staff training schedule, which includes annual competencies is in place, as is a staff appraisal process. More than 50% of the staff have not completed the service provider’s training requirements, nor have they undergone a performance appraisal that is linked to the competency process, within the past 12 months.</p>	<p>Annual staff training and competency reviews and annual performance appraisals are completed by all staff to ensure safe and effective services to consumers.</p> <p>90 days</p>

		2016.		
--	--	-------	--	--

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, 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

End of the report.