

Otago Care Limited - Woodhaugh 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 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](#).

The specifics of this audit included:

Legal entity: Otago Care Limited

Premises audited: Woodhaugh Resthome 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: 16 February 2018 End date: 16 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: 52

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

Woodhaugh rest home and hospital is privately owned. Woodhaugh provides rest home and hospital (geriatric and medical) level of care for up to 73 residents. On the day of the audit there were 52 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, management and staff.

The director is on-site forty hours a week and has attended training related to the management of an aged care facility. He is supported by a facility manager (RN) and team of registered nurses and long serving staff. Staff receive education and have policies and procedures in place to guide them in the safe delivery of care.

There are ongoing environmental improvements and current renovations occurring.

The service has addressed seven of the eight shortfalls from their previous certification audit around, family notifications, complaints, manager and owner training, health and safety, incident management, storage of chemicals, and laundry processes. A further improvement continues to be required around staffing.

This surveillance audit identified improvements required around certified beds, staff education, timeframes, wound management, medication, medical equipment and electrical checks, and the disabled toilet in the upstairs wing.

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.

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is available. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

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.

The facility manager is an experienced registered nurse and is supported by a resident relations manager, the owner and a team of registered nurses and long serving care staff.

Woodhaugh is implementing a quality and risk management system that supports the provision of clinical care. The business plan has documented goals. Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. Policies and procedures are appropriate to provide support and care to residents' rest home and hospital level needs.

Staff receive ongoing training and there is a training plan developed and commenced for 2018. Rosters and interviews indicate sufficient levels of staff that are appropriately skilled with flexibility of staffing around clients' needs.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses are responsible for care plan development with input from residents and family. Initial assessments, care plans and evaluations in resident files were complete within timeframes. Residents confirmed that the care provided meets their needs. The general practitioner reviews the residents three monthly.

Planned activities are appropriate to the residents' assessed needs and abilities and residents advised satisfaction with the activities programme.

Medications are managed and administered in line with legislation and current regulations. Staff responsible for medication administration have completed medication competencies and medication education.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

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

Woodhaugh rest home has a current building warrant of fitness. Renovations are continuing throughout the building.

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 service actively minimises the use of restraint. There is a restraint minimisation policy and procedure that includes processes should restraint be required. There were no residents using enablers and no residents using restraint.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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An infection control policy includes surveillance activities. The surveillance programme is appropriate to the size and complexity of the facility. Infection information is collected and collated monthly by a registered nurse, who is the infection control coordinator.

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	11	0	5	3	0	0
Criteria	0	36	0	5	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. Information about complaints is provided on admission. Interview with residents inform an understanding of the complaints process.</p> <p>There is an electronic record of all complaints. The one complaint, received since the change of ownership in 2017 was reviewed. This complaint included investigation, timelines, corrective actions and resolution. A further complaint from before the ownership change was received via the DHB. The facility manager has submitted all required documentation to DHB within the required timeframe and the complaint has been resolved. The previous partial attainment has been addressed.</p> <p>Discussions with residents and family members confirmed that any issues have been addressed and they feel comfortable to bring up any concerns.</p>
Standard 1.1.9: Communication Service providers	FA	Residents interviewed felt comfortable in approaching the facility manager or clinical lead for any concerns. Residents have the opportunity to feedback on service delivery through three monthly resident meetings held with an age concern advocate. Ten accident/incident forms reviewed evidenced that relatives are informed of any

communicate effectively with consumers and provide an environment conducive to effective communication.		<p>incidents/accidents. The four relatives (two hospital and two rest home) interviewed stated they have been notified promptly of any changes to resident's health status. This previous partial attainment has been addressed.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.</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>	PA Low	<p>Woodhaugh rest home provides residential services for up to 73 residents requiring rest home or hospital (geriatric and medical) level care (23 rooms are approved as dual-purpose). On the day of the audit there were 52 residents – 27 at rest home level care including one on a younger person with disability contract and one respite resident, and 25 at hospital level of care including one respite resident. In the partial provisional audit completed 24/6/14 to add hospital level care, 23 specific rooms were identified as suitable for hospital level care (dual-purpose). The service currently has 25 hospital residents.</p> <p>The facility has been under new ownership since June 2017. The facility manager (a registered nurse) provides clinical and organisational oversight and has been in the role since May 2017. The facility manager (FM) has recently resigned (the FM also undertakes a clinical management role) and is serving out her notice. The director is currently advertising for a replacement clinical manager and the director is intending to become the facility manager.</p> <p>The FM is supported by a full-time director and a resident relations manager. The facility manager's signed job description documents clinical leadership and facility management responsibilities. The facility nurse manager reports to the director and the director is on-site at the facility eight hours a day Monday to Friday. The FM has attended eight hours training related to the management of an aged care facility. The director demonstrated a knowledge of the health and disability care standards and the content and requirements of the DHB contract. The FM has attended seminars on health and safety and employment relations and the director has attended a leadership and management workshop. The previous shortfall has been addressed.</p> <p>The goals and direction of the service are well documented in the business plan and progress toward meeting goals has been documented.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	FA	<p>There are relevant policies and procedures that are reviewed regularly. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes. A quality and risk management programme is in place. The FM facilitates the quality programme and ensures the internal audit schedules are implemented. Corrective action plans have been developed, implemented and signed off when service shortfalls were identified.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Corrective actions resulting from a complaint investigation have resulted in the decision to replace</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>the current call bell system. Evidence of quotes received were sighted and installation of the new system is planned to commence the following month. All quality improvement data is discussed at monthly safety/quality/risk/staff meetings.</p> <p>The monthly collating of quality and risk data includes monitoring accidents and incidents, resident satisfaction and infection rates. Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement. Staff are kept informed regarding results via staff meetings and during staff handovers. There are annual resident satisfaction surveys conducted and analysed with corrective action planning implemented as required. An audit in April 2017 identified and overall satisfaction rate of 88% and identification of areas for improvement including meals and cleaning services. Corrective actions relating to cleaning and laundry services were documented and included evidence of implementation and sign off.</p> <p>The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. A health and safety programme is in place, which includes managing identified hazards. Health and safety is included in the monthly staff meetings. Hazards related to building refurbishment were documented and appropriately managed. The health and safety representative attended relevant training in February 2018 and was knowledgeable on the location and contents of the hazard manual. This previous partial attainment has been addressed.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects all incident and accident information reported by staff on an electronic database. Incident and accident data is collected and analysed monthly and a report documented for the monthly quality/staff meeting. Ten resident related incident forms were reviewed for January 2018. Each event involving a resident reflected a clinical assessment and follow-up by a RN. The previous partial attainment has been addressed. The electronic records included investigation to lower the risk of future occurrences. The neurological observations were evidenced in resident electronic files following unwitnessed falls. Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the director and manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. This was evidenced with the reporting of pressure injuries for one unstageable pressure injury and a planned power outage.</p>

<p>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.</p>	PA Low	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files (two RNs, two HCAs and one support worker) reviewed, evidenced implementation of the recruitment process, employment contracts and completed orientation. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. Woodhaugh has recently hired several new staff in response to an increase in resident numbers including a new support worker role (non-resident care role). However, there are a significant number of staff that are new to the service and staff interviewed reported there are insufficient experienced caregivers (link 1.2.8.1). Two new staff employed in late 2017, evidenced a comprehensive orientation and all staff evidenced a three-month performance review completed. Care staff confirmed that Careerforce training is available.</p> <p>There is an annual education plan being implemented that includes monthly competencies that must be completed by staff. Not all compulsory education has occurred as scheduled in 2017. Two of seven RNs have completed their interRAI training.</p> <p>Residents and families stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	PA Moderate	<p>There is a documented rationale for staffing the service. Twelve residents were admitted from another local facility due to flooding in August 2017. As a result, registered nurse rostered hours have increased by 7.5 hours and care and support staff have increased by 20 hours over a 24-hour period. As a result of the increased occupancy, a high number of new staff have been employed since early August.</p> <p>For the current 52 residents, on day shift there are two healthcare assistants that work a full shift, one that works 8:30 am to 1.00 pm, one from 7am to 1pm, one working from 7.30 am to 1.30 pm and one that works from 7:30 am to 2.00 pm. In addition, there are two support workers whose tasks include making beds and tidying rooms, kitchen cleaning and tray preparation, morning and afternoon tea, restocking linen and assisting the healthcare assistants with tasks that do not involve direct resident care. The afternoon shift is staffed by five healthcare assistants and two RNs. Night shift is covered by one RN, two healthcare assistants and one support worker. Routine showering cares are scheduled for morning shifts only.</p> <p>There is a registered nurse on duty at all times. Registered nurses work eight-hour shifts. In addition to the main registered nurse on the floor, a second registered nurse is rostered on between 7:30 am and 9:30 am each morning and between 5.00 pm and 9.00 pm on the evening shift.</p> <p>The staff are supported by a resident relations manager who assists in arranging resident appointments, ensuring family contact is maintained and residents personal grooming needs are met.</p>

		<p>The facility manager (RN) has resigned effective three weeks from the date of audit and the replacement role of clinical manager has not yet been filled.</p> <p>There are dedicated housekeeping staff who undertake cleaning duties. Laundry is completed off-site. Caregiver and support worker position descriptions document appropriate care and support tasks. These is a cook and two kitchenhands rostered on each day to prepare meals and wash dishes, including cleaning the bain marie.</p> <p>This was confirmed by rosters, registered nurse interview and caregiver interview. The facility manager (RN) and the director are on call at all times.</p> <p>The staff mix on the day included four senior experienced healthcare assistants, and one HCA and two support workers who were recently employed. The recently engaged HCA interviewed stated he received a comprehensive orientation and felt competent to manage allocated tasks. Residents and family interviewed confirmed that staffing levels are adequate. Not all staff interviewed agreed that roster hours were adequate.</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>	PA Moderate	<p>Twelve medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. The medication charts reviewed identified all allergies were noted, however not all three-monthly reviews were documented. All medication charts included indications for use for as required medication.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses an electronic medication system and robotic blisters. All medications are checked on delivery against the medication chart by two registered nurses and any discrepancies are fed back to the supplying pharmacy. Correct medication prescribing was evident in all charts reviewed, however not all medication charts had photo identification. There were no self-medicating residents. Standing orders are not used</p> <p>The medication fridge temperature is recorded regularly and is maintained within an acceptable range.</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</p>	FA	<p>All meals at Woodhaugh are prepared and cooked on-site. There is a four-weekly seasonal menu that was reviewed by a dietitian in February 2015. There is a newly appointed chef who holds food safety qualifications on duty each day. The chef had been employed for five weeks, and has previous experience working in the kitchens at Dunedin public hospital. Variations to the menu are recorded. The chef receives a dietary profile for each resident and is notified of any dietary changes. Special diets such as pureed meals, diabetic desserts and high protein meals are provided. Resident likes, and dislikes are known, and alternative foods offered. Meals are delivered to the satellite kitchen and kept hot in a bain marie. Midday meals were observed on the day of the audit. Meals were adequate and well presented. Residents interviewed commented variably on the meals. The dietitian is scheduled</p>

service is a component of service delivery.		<p>to visit the facility within the month.</p> <p>The main kitchen and satellite kitchen are well equipped. The satellite kitchen was not in use on the day of the audit as the dishwasher was not working. The dishwashers are checked monthly by the chemical supplier for function and chemical effectiveness. Fridges, freezers and cooked food (midday meal) are temperature monitored daily and recorded electronically. All food in the fridges and freezers were covered and dated. There were adequate food supplies sighted in the pantry, fridges and freezers. A cleaning schedule is maintained.</p> <p>A recent resident meeting was chaired by age concern. The new chef has been invited to attend the next meeting.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>Initial assessments and care plans are completed in a timely manner. A written record of each resident's progress is documented. All residents evacuated from another facility were fully admitted to the service. When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. Contact with relatives regarding resident changes was documented within the progress notes on the electronic file. Call bells were evidenced to be attended to in a timely manner on the day of audit. The under 65-year-old resident was interviewed and felt their needs were met, the resident attends activities within the facility and attends a group without the facility. Three residents were interviewed including two respite residents. One stated they were not happy with any part of the service. Four relatives were interviewed (two rest home and two hospital). One hospital resident commented on how well the resident had improved since admission to Woodhaugh. All relatives stated they were happy with the service, and confirmed they are well informed of changes.</p> <p>The present owner was unsure of when the dietitian last visited the service, and had arranged a dietician to visit the facility the week after the audit.</p> <p>Dressing supplies were available and treatment rooms were well stocked. Wound assessment and wound care plans and evaluations were recorded for nine minor wounds, one chronic ulcer. There were two stage two pressure injuries and one unstageable pressure injury of which had been reported as section 31. However, not all wounds were documented individually. Not all residents with a wound have a short-term care plan in place to guide caregivers on care of the dressing during personal cares.</p> <p>The facility manager was able to describe wound care and continence advice is available as needed. The wound care specialist nurse has been involved in the care of a resident with an unstageable pressure injury. The dietitian has been booked to assess residents with weight loss.</p> <p>Monitoring forms and short-term care plans are available for use to record interventions for short-term needs.</p>
Standard 1.3.7:	FA	The service employs an activities coordinator over three days (Monday, Wednesday and Friday). Two other staff,

<p>Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>including one caregiver and an office worker are trained in providing exercises for residents on Tuesday and Thursday. They attended a falls prevention course through Otago University early 2017. Training is planned for the activities coordinator to gain a diversional therapy qualification.</p> <p>An activity programme has been set up in consultation with the residents and includes activities of interest that meets the abilities of rest home and hospital residents. One-on-one time is provided with residents who are unable to or choose not to participate in the activity programme. Community links include, visits from library, community and school groups. Preschool groups come to the facility to sing and play instruments. There are monthly church services. Bus trips are planned weekly subject to driver availability. The service does not have a bus/van of their own. The activities coordinator has a first aid certificate. The YPD resident attends a local epilepsy group, goes to the movies with friends, and is very active within the facility activities programme.</p> <p>Three monthly resident meetings provide an opportunity for feedback on the activity programme.</p> <p>Resident profiles and individual activity plans were sighted in the six resident files reviewed. The activity plan and the care plan are reviewed six monthly (link 1.3.3.3).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Written care plan evaluations were completed, and long-term care plans updated with changes. Not all interRAI assessments and long-term care plans have been reviewed within required timeframes (link 1.3.3.3). One hospital resident had not been at the service six months, for an evaluation of the long-term care plan. Care staff stated the RN involved them in the review of resident care plans. The GP completes three monthly medical reviews. The GP commented on no provision for MDT meetings. Progress is evaluated against the resident goals with the long-term care plan amended for any changes to care. Progress notes are comprehensive, and evidence follow-up of incidents or change in resident status, caregiver notes indicate position changes for residents, changes in behaviours and other significant reporting.</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,</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly; and these were all stored safely throughout the facility. Safety data sheets are available. Sluice doors were identified as locked during the audit. The previous finding has been addressed.</p>

infectious or hazardous substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	<p>The facility displays a current building warrant of fitness which expires on 18 February 2018. Equipment sighted included- scales suitable for wheelchairs, electric beds, air pressure mattress, pressure relieving cushions, standing hoist and two full body hoists. Staff interviewed feel they have enough equipment to care for hospital level residents. Essential contractors are available 24 hours. A preventative maintenance record is maintained, and corrective actions are signed as completed, however, not all electrical equipment has been checked as required.</p> <p>There are ramps in place where original would have been in the original buildings to ensure ease of access to all areas of the downstairs. There is a lift installed for residents to access the upstairs level. Staff confirm the stairs are not utilised by residents. The owner/director oversees the maintenance</p> <p>The two lounge areas are spacious and adequate space to provide individual and group activities.</p> <p>There is safe access with ramps and rails to the outdoor areas and internal courtyard with seating and shade.</p>
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.	PA Low	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. A number of toilet and shower facilities downstairs are suitable for both rest home and hospital residents; however, the toilet facilities upstairs do not meet requirements for hospital level. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
Standard 1.4.6: Cleaning And	FA	Dedicated cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents

<p>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>		<p>interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>The laundry service is contracted out and only small personal items are laundered on-site. Residents interviewed were satisfied with the laundry service. Excess dirty laundry bags were not sitting around and dirty laundry is removed daily. This previous finding has been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. There is close liaison with the GPs who advise and provide feedback/information to the service. Infection control events are collated monthly and analysed. Information and graphs are displayed for staff. Infection control matters and surveillance is discussed at staff meetings (minutes sighted). There have been no outbreaks since last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. Staff have not received training around managing behaviours that challenge or restraint in the last two years (link 1.2.7.5).</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)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	Woodhaugh rest home provides rest home and hospital level care services. There is an annual quality and risk management plan documented including goals for 2018. The new owner stated all room were suitable for use as dual-purpose beds, however the service is only certified for 23 hospital level residents. The service is unaware which rooms are certified for hospital level and therefore hospital residents are situated in various rooms.	The facility has 23 certified hospital beds (dual-purpose). Not all hospital residents were in certified dual-purpose rooms. On the day of audit, the facility identified they currently have 25 hospital level care residents. Advised that the service increased hospital residents from another facility that was flooded. Since the draft report, the service has provided feedback that some of these residents have moved back to their original facility and they now only have 20 hospital residents.	Ensure hospital residents are situated in certified dual-purpose beds. 30 days

<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>An in-service training programme is being implemented for staff and attendance records are being maintained. The frequency of mandatory training is dependent on the type of in-service and ranges from six months, one year, and two-yearly. Compulsory training included code of rights, health and safety manual handling and hoist use, emergency procedures and chemical safety, however not all required education has been provided. A comprehensive education planner is being implemented for 2018.</p>	<p>The following education sessions have not been documented as occurring within the last two years: Wound management, privacy and confidentiality, abuse and neglect, falls management, challenging behaviour and restraint.</p>	<p>Ensure all mandatory education is completed as per training plan. 90 days</p>
<p>Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>The service has made significant improvements with rosters including additional RN and career hours and the addition of support workers. All care staff interviewed (except one) stated there were generally sufficient hours to manage cares, that rostered hours were increased to meet changes in resident needs and that RN's were readily available and responsive to all requests. Care staff also stated that all leave is covered by replacement staff. The service has also introduced a resident relations manager who ensures that all residents receive care and assistance to attend appointments and activities</p>	<p>The service has increased staffing numbers since the previous audit, however staff retention continues to be an issue for the service. (i) Five of seven RN's, six of thirteen caregivers and seven of seven support workers have been employed within the last 90 days. (ii) A new role (support worker role responsible for non-resident care duties) has been introduced to assist the caregivers, however five caregivers undertaking daily cares rostered on morning shift is stretched to manage the daily cares and support needed for the current 25 hospital and 27 rest home level care residents; (iii) The clinical manager (also the FM role) has resigned effective three weeks from the date of audit and the replacement role of a new clinical manager has not yet been filled.</p>	<p>Ensure rosters include sufficient experienced care staff to provide care and develop a plan to increase staff retention. 60 days</p>
<p>Criterion 1.3.12.1 A medicines management system</p>	<p>PA Moderate</p>	<p>Twelve electronic medication charts were reviewed. All medication charts reviewed were charted clearly. 'As required' medications were charted correctly and documents indications for</p>	<p>(i) Three out of twelve medication charts reviewed did not have photo identification. (ii) One out of eleven (one was a recent admission) had no evidence of three-month</p>	<p>Ensure medication charts have photo</p>

<p>is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>use. All controlled drugs were signed by medication competent staff, one of whom was an RN. Allergies are documented, however not all files showed evidence of a three-monthly review by the GP or photo Identification. Signing sheets corresponded with the medication charts. Staff signs the date and time of administration for 'as required' medications.</p>	<p>review.</p>	<p>identification and evidence of three-month GP review. 90 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>The registered nurses are responsible for all aspects of assessment, care planning, service provision and review, within timeframes that safely meet the needs of the resident. Not all resident files reviewed had interRAI re-assessments documented in the required timeframes and not all residents evidenced the long-term care plan had been reviewed in required timeframes. The GP reviews all residents on admission and within required timeframes and as required.</p>	<p>(i) One of two long-term hospital residents reviewed, did not have an interRAI reassessment completed within six months. (ii) One of three long-term rest home residents reviewed identified the long-term care plan has not been updated or reviewed within six months.</p>	<p>(i) Ensure that interRAI re-assessments are completed within the required timeframes. (ii) Ensure all long-term care plans are reviewed within required timeframes. 90 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and</p>	<p>PA Low</p>	<p>Short-term care plans are in place for short-term needs such as weight loss and infection, however, not all residents with wounds had a short-term care plan in place. Comprehensive wound care assessment, plan and evaluations were implemented, however, not all wounds were</p>	<p>(i) Three wound care charts out of five, documented more than one wound. (ii) Four out of five residents with wounds did not have interventions documented to support current wounds in either a short-term care</p>	<p>(i) Ensure only one wound is documented on each wound care</p>

<p>contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>documented with individual treatment plans.</p>	<p>plan or the long-term care plan updated.</p>	<p>plan. (ii) Ensure all residents who have a wound have interventions related to the resident having a current wound in either a short-term care plan or the long-term care plan updated.</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>The service displays a current building warrant of fitness. A preventative building maintenance programme ensures that all legislation is complied with. The environment and buildings are maintained. Not all electrical equipment is tested and tagged and not all medical equipment has been calibrated and checked.</p>	<p>Not all equipment has been checked as per schedule. (i) Sitting scales were due to be checked on 29 November 2017. (ii) The air pressure mattress did not evidence either an electrical check or medical equipment check. (iii) The light in a resident room was due on 13 August 2016.</p>	<p>Ensure all electrical equipment is checked annually, and all medical equipment including weight scales are calibrated and checked on an annual basis.</p>

				90 days
<p>Criterion 1.4.3.1</p> <p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>	PA Low	<p>There are adequate and sufficient toilet/shower facilities to accommodate the rest home and hospital level residents in all wings on the ground floor. There are four wings on the ground floor - Inverleigh (15 rooms) Millhouse (15 rooms) the Villa (12 rooms), Holmstead (13). Upstairs area (the Gables) has 15 rooms. The Villa wing, Homestead wing and Millhouse wing have mobility bathrooms and toilets suitable to provide hospital level care. The upstairs wing (Gables) is currently occupied by rest home residents only. The upstairs wing has only recently been used, however renovations to provide a mobility toilet have not been completed, therefore the floor remains unsuitable for hospital level care. This continues to be a finding related to the previous partial provisional audit 24 June 2014 around adding hospital level care.</p>	<p>The wall between two toilets has been removed leaving two toilet bowls with two entrances. Only one toilet is used at any time, however the toilet is not suitable for disabled access and one toilet should be removed.</p>	<p>Complete the renovations to the bathroom and remove the excess toilet. Ensure the provision of a mobility toilet in the upstairs Gable wing prior to occupancy of hospital level residents.</p> <p>60 days</p>

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.