

# Rosewood Resthome Limited - Rosewood Resthome and Hospital

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## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Rosewood Resthome Limited
<b>Premises audited:</b>	Rosewood Resthome and Hospital
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
<b>Dates of audit:</b>	Start date: 23 July 2019    End date: 24 July 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	61

# 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.

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
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Rosewood Rest Home and Hospital provides rest home dementia, psychogeriatric and hospital level care (medical and geriatric) for up to 66 residents. This privately-owned service is managed by a general manager and a facility manager with support from three clinical care coordinators. Residents were interviewed during the audit; however, the information obtained was not able to be used to contribute to the report. Family members interviewed were positive about the care and support provided in this facility.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with the owner, residents, family members, managers, staff, two contracted allied health providers and a general practitioner.

This audit has resulted in three areas identified as requiring improvement. These relate to consent and enduring power of attorney/welfare guardian documentation, residents' records, and chemical handling and education.

## Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of community services and specialist health care providers to support best practice and meet resident's needs.

The service has a complaints policy and associated procedures which comply with Right 10 of the Code. Staff interviewed understood the complaints process including where to access complaint forms, how long the process should take and that feedback would be provided in a timely manner.

## 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 low risk.
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Rosewood Rest Home and Hospital is privately owned and is managed by a facility manager with oversight from a general manager. 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 to monitor and report on the services provided, including regular weekly written reporting to the general manager, who in turn reports to the director. An experienced and suitably qualified person manages the facility.

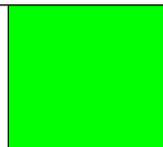
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and relatives. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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.

Any prospective resident is required to have a needs assessment prior to entry. Access to the facility is appropriate and efficiently managed with relevant information provided to the prospective residents and their families.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans and activity plans are individualised, based on a comprehensive range of information. Appropriate planning and interventions occur for any new problems that arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed in accordance with a registered food control plan.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The facility meets the needs of residents and was clean and well maintained. There are current building warrants 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. Protective equipment and clothing are available for use. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite 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. Response to call bells is monitored to ensure residents' needs are met. Security is maintained.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The organisation has implemented policies and procedures that support the minimisation of restraint. Restraint is only used as a last resort and at the time of audit no restraint or enablers were in use. A system is in place to ensure comprehensive assessment,

approval, monitoring and review occurs when restraint is used. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler use processes and of managing challenging behaviours.

## 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 prevention and control programme, which aims to prevent and manage infections is reviewed annually. The programme is led by a new trained infection control coordinator with support from the facility manager who has experience in the field. Specialist infection prevention and control advice is able to be accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures. Regular education on infection prevention and control is available for staff.

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)
<b>Standards</b>	0	42	0	1	2	0	0
<b>Criteria</b>	0	89	0	1	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Rosewood Rest Home and Hospital (referred to as Rosewood) has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy.</p> <p>The facility manager informed that training on the Code is included in the orientation process for all staff employed and is provided in ongoing training every year. This was verified in staff training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	PA Moderate	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained using the organisation's standard consent form. Medical practitioners were involved in completing and signing documents guiding advance directives.</p> <p>Few residents had documentation on file confirming enactment of the health and welfare enduring power of attorney, or evidence of a welfare guardian having been appointed by the court. Also, there was a lack of clarity around who was signing significant documents for whom and what authority they had to do so. These issues have been raised for corrective action.</p>

consent.		Staff were observed to gain consent as far as this was possible for day to day care and at the very least explained what they were doing to residents.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	During the admission process, family members and residents are given a copy of the Code, which includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were displayed and available in the facility. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The manager informed that there has not been any recent example of the involvement of Advocacy Services; however, they have used a social worker, who was a resident's court appointed welfare guardian, to assist with addressing a family concern.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits to local cafes, shopping trips, walks and activities. The diversional therapist explained that visiting entertainers, or other community members leading activity sessions also take time to talk with residents when they visit, which was observed during the audit.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. According to the manager and staff interviewed, family members are welcome around the clock if a resident is receiving end of life cares.</p>
<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 complaint policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents' family members on admission and there is complaint information, copies of the Code and forms available in the reception area.</p> <p>The complaints register reviewed showed that eleven complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans reviewed showed investigations and required follow up occurred, corrective actions are documented, and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. There have been no complaints received from external sources since the previous audit. However, one complaint made through the Health and Disability Commission prior to that time remains open. Correct processes have been followed and a response made in the required timeframe following the results of an independent review. While awaiting the outcome the facility manager has implemented corrective actions including education and staff reminders.</p>

		All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents were not able to express their familiarity with the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service); however, family members interviewed confirmed these had been discussed with them when their relative entered the service and that they had received information about them.</p> <p>The Code in both English and te reo Māori was sighted on display in two different parts of the building. Information on advocacy services, how to make a complaint and feedback forms were available in each of the nurses' stations and in the reception area at the front of the building.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Families confirmed that the residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Throughout the audit, staff were observed to maintain residents' privacy, and where relevant to give residents choices. A clinical care coordinator stated that caregivers are regularly reminded of the need to make sure curtains and doors are shut when doing personal cares. All residents have a private room and although there are two double rooms, both currently only have one resident.</p> <p>Residents are assisted to maintain their independence. Documentation in the care plans described each person's level of independence according to their abilities and staff were observed assisting residents and reminding them of the next step in a process, as with hand washing, eating a meal and a person putting on their shoes.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Family members interviewed informed they had not seen any example of any type of abuse, or examples of disrespect, in this facility.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as</p>	FA	<p>There is a current Māori health plan developed with input from cultural advisers as well as an ethnicity awareness policy and procedure. The principles of the Treaty of Waitangi and the importance of whānau are incorporated into policy documentation and two staff provided explanations of how these are evident in</p>

<p>Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>day to day practice. Te whare tapa wha model of care had been used as part of the service delivery plan for one resident.</p> <p>Staff support the three residents in the service who identify as Māori to integrate their cultural values and beliefs at the level they are wanting, or that the family have informed they are accustomed to. Guidance on tikanga best practice is available and is supported by staff in the facility who identify as Māori. Māori cultural support is available from a cultural advisor from a nearby public hospital who visits each resident shortly after their admission, intermittently after that and as required. It was not possible to interview any Māori resident or their whānau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Assessment sections of the care plans and the activity plans include records about the culture, values and beliefs. Individualised responses are recorded, and applicable personal preferences and special needs are integrated into the interventions for care planning and activity plans that were reviewed. Family members verified that they were consulted on their individual culture, values and beliefs and that from what they hear and see, the staff respect these. According to the facility manager, excepting for those who identify as Māori, all other residents identify as New Zealand/European. None of the residents currently leave the facility on a regular basis specifically for cultural or spiritual reasons. An interdenominational service is held within the facility each month.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Family members and two visiting health professionals who were interviewed, stated that residents were free from any type of discrimination, harassment or exploitation. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff sign a Code of Conduct when they commence employment. Registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, especially the psychogeriatrician, mental health services for older persons, and the palliative care nurses with whom there is open communication whenever needed. The general practitioner (GP) confirmed the service seeks prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education, including conferences and workshops and there are ample opportunities for in-service education.</p>

		Other examples of good practice observed during the audit included good communication of staff with residents, ensuring residents were happy and comfortable and providing immediate attention if there was anything they could assist with. The activity programme is diverse and involves residents at both individual and group level.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Family members stated they were kept well informed about any changes to their relative's status. They also informed they are advised in a timely manner about any incidents or accidents and the outcomes of regular and any urgent medical reviews. This was supported by notes in the family communication section of residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>The manager and clinical care coordinators know how to access interpreter services, although reported this has only been required once, which was for a family member of a previous resident. It was also reported that there has never been a need to use staff to assist with interpretation. Staff informed that there have been times when pen and paper has been used to assist with communication. They also informed that if a resident is progressively, or suddenly less responsive to verbal communication then a referral is made to the ear clinic.</p>
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The strategic business plan, which is reviewed annually, outlines the purpose, mission, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. Clinical coordinators provide weekly reports to the facility manager, who in turn collates a weekly report to the general manager. The general manager is responsible for reporting to the owner/director. A sample of reports were reviewed and showed adequate information to monitor performance is being reported including overviews of health and safety, occupancy, financial performance, staffing, service delivery, adverse event reporting, emerging risks and issues, and updates on previously identified risks. Examples of associated reports were also reviewed. The owner/director and the general manager both confirmed the reports are comprehensive and provided sufficient information.</p> <p>The service is managed by facility manager who is overseen by a general manager who is based in the North Island. The facility manager, who has been in the post for four years, is a registered nurse with a current practising certificate and is suitably experienced. 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 attendance at conferences and aged care sector study days. She is supported by the general manager, also a registered nurse, who maintains contact at a minimum of weekly and visits the facility two weekly. The owner/director also takes an active interest. The facility manager is further supported by three clinical coordinators who work in each</p>

		<p>of the specialty areas of the facility, rest home (dementia), hospital and psychogeriatric unit.</p> <p>The service holds contracts with the district health board for 26 rest home (dementia) beds, 20 beds in the psychogeriatric unit and 20 aged care hospital level beds including a support care contract to provide end of life care. At the time of audit, 24 residents were receiving services under the rest home (dementia) contract, 19 under the psychogeriatric contract and 18 under the aged care hospital level contract. No residents were receiving end of life care.</p>
<p>Standard 1.2.2: Service Management</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, an identified clinical coordinator carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by clinical coordinator who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well and responsibilities are understood.</p>
<p>Standard 1.2.3: 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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls, pressure injuries, skin tears and unexplained bruising.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. These are provided by an external quality consultant who as part of the contract is responsible for ensuring documentation is current, regularly reviewed and meets the requirements of the document control policy. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are required to sign to acknowledge they have read any new or updated policy document.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly management meeting, registered nurse meetings, monthly quality meetings and staff meetings. Staff reported their involvement in quality and risk management activities through the reporting and investigation of incidents together with internal audit activity. 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 tracked. Relevant</p>

		<p>corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and next of kin satisfaction surveys are completed annually. The most recent survey showed overall high satisfaction with corrective actions plans developed for any item where satisfaction was below 85%. A review of quality improvement plans confirmed concerns have been addressed.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. A hazard and risk register confirmed appropriate identification of risks and the implementation of mitigation strategies. Staff interviewed described their involvement in health and safety activity. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>Staff document adverse and near miss events on an electronic system. A sample of incident records reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported weekly in the management reports and monthly to the quality improvement meetings. Meeting minutes reviewed confirmed reporting and discussion of incident causes, trends, the development of action plans and follow up on improvements made.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. There have been three notifiable incidents since the last audit; a power outage, a pressure injury and an unexpected death. The facility manager described the process followed and documentation related to each incident was sighted to confirm essential notification reporting requirements were met.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes interview, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Position descriptions reviewed were current and defined the responsibilities of the various roles. 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 and includes support from a 'buddy' through their orientation period. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period for recently employed staff.</p> <p>Continuing education is planned on an annual basis, and includes education identified as required from incident analysis. Mandatory training requirements are clearly identified. Care staff records reviewed confirmed staff have completed a New Zealand Qualification Authority education programme to meet the</p>

		<p>requirements of the provider's agreement with the DHB. The facility manager is the internal assessor for the programme. Thirty-three staff working in the dementia care area have completed the education required by the contract, eight staff are enrolled and have commenced education, and a further five staff employed since April 2019 have yet to be enrolled. Palliative care education to meet the requirements of the support care contract is underway. Regular in-service education supplements and reinforces the external education provided. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. There is a systematic process in place to ensure mandatory training requirements are completed in a timely manner and records reviewed demonstrated completion of the required training and 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>	FA	<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 (24/7). The facility adjusts staffing levels to meet the changing needs of residents. Two registered nurses are on duty at all times one in each of the hospital and the psychogeriatric units. In addition, a registered nurse works 32 hours per week in the rest home. The registered nurses are supported by three caregivers in each area during the day and one in each area at night. At least one staff member on duty has a current first aid certificate and this person is identifiable as noted on the roster.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Family members interviewed supported this. Observations and review of a six-week roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Short notice gaps are covered by other staff familiar to the residents, who are not rostered for that shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the Momentum electronic database.</p> <p>Records were legible; however, the name and designation of the person making the entry was not always identifiable. Due to the frequency of the occurrence a corrective action has been raised.</p> <p>Archived records are held securely on-site upstairs and are readily retrievable using a cataloguing system.</p> <p>Residents' files are retained for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service and by specialist referral from specialist mental health services/older persons' mental health services for those going into rest home (dementia) and specialist hospital (psychogeriatric) services. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC, the person's GP, social worker, older persons' mental health and/or the hospital as applicable, for residents.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed service agreements were on file for most, but not all, residents. Refer corrective action in 1.1.10.2 as the signing processes for these agreements varied with some initialled on each page and some only signed at the end of the document. The person signing the document, their relationship, or whether they had EPOA status or welfare guardianship for the resident, was not always clear.</p> <p>Service charges comply with the varied contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Internal transfers may occur between dementia rest home and the hospital or the specialist dementia hospital services at Rosewood. Such transfers may occur in the event a resident's overall health or behaviours change or deteriorate. This involves updating the interRAI and requesting a formal needs reassessment to be undertaken prior to the person transferring between services. A stay in an acute ward or in an aged care assessment and treatment unit may be required between such a transfer.</p> <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed the staff at Rosewood had remained in constant contact with the acute service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and</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 using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and</p>

<p>timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>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 registered nurse 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 registered nurses for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and entries were accurate.</p> <p>The record of temperatures for the medicine fridge reviewed were within the recommended range.</p> <p>Prescribing practices included a record of the date on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. Short term medicines were time-framed, and the person's allergy status noted. All GP reviews of residents' medicines were within three months, as required. There were no residents self-administering medications at the time of audit and the registered nurses stated that it would be inappropriate within this setting.</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>	<p>FA</p>	<p>A comprehensive set of documents sit within a food services manual that was last updated April 2019. Food services are provided on site by a qualified cook and kitchen team and were 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 (26 March 2018). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Christchurch City Council on 31 January 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. A quality improvement plan is in place to ensure food in the hospital area is kept warm, especially as some residents need to wait to receive assistance. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</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 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>

		Evidence of resident satisfaction with meals was verified by family interviews and in a satisfaction survey (January 2019). Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a health status and clinical risk assessment, dietary profile and nutritional assessment, falls risk, continence and pressure injury risk, as a means to identify any deficits and to inform care planning. Information from GPs and family members is also used for assessment purposes.</p> <p>The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed by one of the trained interRAI assessors on site. Family members interviewed confirmed their involvement in the assessment processes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Separate behavioural management plans that reflect triggers and describe relevant interventions are available and being reviewed as applicable. Any change in care required is documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans but also stated that staff regularly provide updates when they call into the facility.</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>	FA	<p>Documentation, observations and interviews verified the 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 that a high level of care is provided, especially when some of the residents present with behaviours that challenge. Healthcare assistants 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 a trained diversional therapist holding the national Certificate in Diversional Therapy, and two activities coordinators. Caregivers assist the activities team by ensuring residents are ready for specific activities on time.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. From this individualised activity plans are developed and implemented. All residents in the dementia rest home and the specialist hospital services have a 24-hour activity plan.</p> <p>A monthly activities schedule is developed for the entire facility. Planned activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through ongoing discussions with the activities team.</p> <p>Activities for residents from the specialised hospital services 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 spending time one-on-one, playing games and normal daily activities such as afternoon tea. Outings are arranged to join with a men's group to provide appropriate social interactions for the men.</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 registered nurse/clinical care coordinator.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, and as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the long-term plan of care. Examples of electronically recorded short-term care plans being consistently reviewed were viewed for infections, changes in behaviours and skin tears. Unresolved short-term problems are added to long-term care plans as necessary. Families/whānau interviewed provided examples of involvement in evaluation of progress.</p>

		Each resident's activity needs are evaluated twice each month as recorded in the activities progress notes and as part of the formal six-monthly care plan review.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including for semi-urgent surgery, social work and occupational therapy input. The resident (regardless of their level of understanding or ability to recall) and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Any acute/urgent referrals following a change in a resident's health status are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. This may involve a public hospital reassessment of the resident's medication and examples of this having occurred were discussed.</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>	PA Moderate	<p>Processes for the management of waste and infectious and hazardous substances are documented and described the requirements of staff. The policy includes rubbish handling, kerbside recycling, kitchen waste and medical waste. A contracted provider collects on site waste.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products, they also provide relevant training for staff. Chemicals were stored securely, appropriate signage was displayed where necessary, and material data sheets were available and accessible to staff. Personal protective clothing appropriate to the risks associated with the handling of chemicals was available however, housekeeping staff were able to describe the correct personal protective equipment to wear when handling individual chemicals.</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 1 April 2020 is publicly displayed in each building.</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 was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required and</p>

		<p>that any requests are appropriately actioned. Family members interviewed reported they were happy with the environment.</p> <p>Resident rooms were personalised and provide adequate space for residents who use mobility devices. Rooms look out over the courtyard or gardens and residents were able to access secure outside spaces easily as well as being able to mobilise freely within each unit. The facility layout allowed for safe purposeful walking including easy access to safe and secure outdoor areas. External areas are well maintained with shrubs and gardens for residents and families to enjoy; they are appropriate to the resident groups and setting.</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 facility. There is a mix of ensembles with toilets and showers and bathrooms shared between two rooms. In the rest home area, the six rooms without an ensuite are serviced by two bathrooms and an additional toilet. All facilities afford privacy for residents when being assisted with their personal hygiene and facilities are easily identified. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water at the tap is maintained at safe levels and monitored monthly, this was verified by a review of internal monitoring reports for all units.</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 occupation with the two rooms in the rest home designated as doubles being used for single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and family members reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</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>safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining 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>	<p>FA</p>	<p>Laundry is undertaken on site in two dedicated laundry areas by dedicated laundry staff who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.</p> <p>There is a small designated housekeeping team responsible for cleaning who have received appropriate orientation. Cleaning trolleys are not left unattended when in use. Bulk chemicals are stored securely in a lockable cupboard and were seen in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and examples of completed audits were seen.</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>	<p>FA</p>	<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 described 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 on 7 November 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 28 June 2019. The orientation programme includes fire and security training which is repeated annually. Staff confirmed their awareness of the emergency procedures and have undertaken training in the Coordinated Incident management Systems (CIMS).</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted. These meet the regional Ministry of Civil Defence and Emergency Management recommendations for the number of residents and staff. A generator is available on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors are locked as part of the security in the rest home (dementia) and psychogeriatric units and windows locked by staff at a predetermined time. In the general hospital doors are locked each evening at an agreed time. Visitors can access the facility via a doorbell. Camera surveillance of hallways, communal areas and the entry is undertaken.</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. Access to the secure external garden and courtyards is via the lounge areas. Shade is available. Heating is provided by underfloor heating in residents' rooms in the communal areas in the hospital and individual heat pumps in the rest home. Areas were warm and well ventilated throughout the audit and staff confirmed the facility 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>	FA	<p>Health and safety documentation includes a comprehensive set of infection prevention and control (IPC) policies and procedures, which underpin the service provider's infection prevention and control programme. The infection prevention and control programme is reviewed annually and the latest report covers an overview of the infection surveillance results, a review of hand hygiene and use of personal protective equipment, a review of household and laundry and a review of infection related education.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. This person accepted the role approximately a week prior to the audit and is being supported by the facility manager, who has previously been an infection control coordinator. Infection control matters, including infection surveillance results, are reported to the quality and risk committee meetings and to staff meetings.</p> <p>Residents and staff are offered the flu vaccination each year. 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 and described their use of personal protective equipment to help prevent the spread of infection.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse has just been appointed to take on the role of infection control coordinator. Additional education to upskill the registered nurse has been organised. Meantime, the facility manager who has appropriate skills, knowledge, qualifications and experience for such a role is supporting the new appointee. The infection prevention and control team includes management and clinical nurse coordinators from each key area.</p> <p>Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the local public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator and the facility manager confirmed the availability of resources to support the</p>

		programme and any outbreak of an infection.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed just before the audit and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education has been provided by suitably qualified registered nurses, the facility manager and the previous IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. The most recent infection prevention and control in-service education was in May 2019 and as per usual practice a record of attendance was recorded. Two qualified registered nurses undertaken annual infection control competencies with all staff.</p> <p>Education opportunities with the residents in this service are limited; therefore, staff are taking on the responsibility for ensuring residents maintain good practice in relation to infection prevention and control by assisting them with handwashing and ensuring they have enough to drink, for example.</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</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. Records showed the IPC coordinator at the time has reviewed all reported infections. 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 to identify any trends, possible causative factors and</p>

<p>specified in the infection control programme.</p>		<p>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 clinical nurse coordinators, the infection control team and the quality committee. Data is benchmarked externally with other aged care providers.</p> <p>The surveillance process has alerted the service provider of the higher than expected levels of urinary tract infections in one particular hospital area and high numbers of recent upper respiratory tract infections. Quality improvement plans have been developed and are ready for implementation.</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 differences between a restraint and an enabler and note that enabler use is voluntary. The use of restraint is actively minimised. A restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>An electronic restraint register is maintained and was sighted. On the day of audit, no residents were using restraints and no residents were using enablers. Review of the restraint register and monthly reporting confirmed the last resident was removed from the register six weeks prior to the audit following a multidisciplinary review.</p> <p>A restraint approval committee monitors restraint use and reports to the quality improvement and management meetings. Internal audits are conducted six-monthly to confirm the required documentation has been completed and that ongoing monitoring is occurring. Approved restraints are bed sides (as a restraint), waist belts around the resident and chair, which is intended for use where a resident may attempt to move from a chair without assistance of staff or mobility aids, and the risk of injury is high, and lazy boy, fall/out chair. Environmental restraint as it relates to dementia care residential facilities to ensure a secure environment is defined within the restraint policy and has been signed off by management.</p> <p>Staff interviewed had a good understanding of the different types of restraint and their associated risks. Staff were able to describe the processes followed for restraint use including assessment, approval, consent, care planning of alternative strategies, monitoring, risks, documentation and review. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</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 1.1.10.2</p> <p>Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.</p>	<p>PA</p> <p>Moderate</p>	<p>Consent forms were in residents’ files; however, the identity of the person signing them was not always evident.</p> <p>Two residents had documentation demonstrating a court appointed welfare guardian was involved and two copies of enduring power of attorney documentation had letters confirming they had been enacted. Two copies of personal and property enduring power of attorney documentation were dated after the resident had been admitted to the dementia service. Four other residents’ files had neither enduring power of attorney, nor welfare guardianship documentation.</p> <p>Signed service agreements were on file for most but not all residents. The signing processes for these varied with some initialled on each page and some only signed at the end of the document. The person signing the document, or their relationship to the resident, was not always clear.</p>	<p>There is inconsistency in ensuring the legal requirements are met in relation to obtaining consent, Enduring Power of Attorney/Welfare Guardianship documentation and signing of service agreements.</p>	<p>Enduring Power of Attorney/Welfare Guardianship documentation meets legal requirements and where applicable, enduring power of attorney documentation requires evidence in the resident’s record that it has been enacted.</p> <p>90 days</p>

<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	<p>PA Low</p>	<p>The date and the signature of the author of entries into progress notes were evident for all entries in the health records. However, the signatures were not legible, and the name of the assignee was not consistently written alongside the signatures. Likewise, only a small number of designations of the author were noted and of these a number were unable to be easily identified.</p>	<p>The signed progress notes do not always have a legible name and/or designation alongside the entries.</p>	<p>The author of entries into progress notes is identifiable with a legible name and designation alongside each entry.</p> <p>180 days</p>
<p>Criterion 1.4.1.6</p> <p>Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.</p>	<p>PA Moderate</p>	<p>Housekeeping staff are the designated chemical handlers. Three housekeeping staff interviewed correctly identified how to isolate and manage a chemical spill. There is provision and availability of protective clothing and equipment which is appropriate to the risks. However, housekeeping staff were unable to describe the correct personal protective equipment to wear when handling individual chemicals. One staff member has completed the required Chemical Handling Approved Handler Training (HSNO), however a further two employed since 2018 have not and as a result are unsure of the risks and cannot demonstrate the appropriate protective equipment and clothing to use. This was confirmed by observation, interview and a review of staff files.</p>	<p>Not all housekeeping staff, have completed chemical handling training and as a result are not aware of the risks of handling chemicals and cannot demonstrate the correct personal protective clothing to wear.</p>	<p>Provide evidence that all staff involved in the handling of chemicals have received training, are aware of the risks associated with the use of chemicals and can demonstrate the correct use of personal protective clothing.</p> <p>90 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.