

# Cromwell Business Limited - Cromwell House 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 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:** Cromwell Business Limited

**Premises audited:** Cromwell House and Hospital

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

**Dates of audit:** Start date: 6 August 2020 End date: 7 August 2020

**Proposed changes to current services (if any):** This audit confirmed reconfiguration of an office room to be a double bedroom, which increases the total number of beds from 50 to 52. The audit confirmed that the room can be used for hospital or rest home level of care. A letter from the Ministry of Health dated 16 June 2020 confirmed that the room was able to be used from the date of the letter with verification to be provided at this audit.

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

# Executive summary of the audit

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## Introduction

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

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

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

Cromwell House and Hospital currently provides hospital (geriatric and medical), rest home and dementia level care for up to 50 residents with a further two beds in a single room verified as being able to support two residents at either rest home or hospital level of care. The total number of beds if approved by the Ministry of Health will be 52. On the day of the audit there were 40 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures; the review of residents and staff files; observations; and interviews with residents, family, management, staff, and a general practitioner.

The service is managed by a director/chief executive officer, manager (registered nurse), and a clinical leader (registered nurse).

Improvements are required to the quality programme; staffing; food service; dining and lounge areas for rest home residents.

## 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.
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Policies are documented to support resident rights. Systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

## 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.
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The service is owned and operated by three directors. A business plan includes the vision, values, and philosophy of care. The clinical leader is a registered nurse with a current practising certificate who has been working in the aged care area for many years. The manager is a registered nurse and provides clinical and operational oversight.

There is a documented quality and risk management system. There are a range of policies, procedures, and forms in use to guide practice. Data related to improvement of service delivery is collected. An internal audit schedule is in place with audits completed as per schedule. Adverse events are documented. Corrective action plans are documented when issues are identified.

The human resource management system is documented in policy with recruitment completed as per policy. There is a documented orientation and annual training plan.

There is a documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home, hospital and the dementia unit.

## 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 low risk.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist has documented the activity programme to meet the individual needs, preferences and abilities of the residents, particularly in the dementia unit, with some activities provided to residents at hospital level of care or in the rest home. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Snacks are available at all times.

## 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 low risk.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are currently two shared rooms, but another has been verified at this audit as being suitable to be used by two rest home or hospital residents. All other bedrooms are single. There are adequate communal spaces in the dementia unit and in the hospital area. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Laundry is done off site. Cleaning services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

The dementia unit is a secure area.

## 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.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training around management of challenging behaviour. There was one enabler used on the day of audit and no restraint in use.



## 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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks. Covid 19 guidelines are in place.

## 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	41	0	3	1	0	0
<b>Criteria</b>	0	89	0	3	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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>Policies and procedures are in place to ensure resident rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training plan. Staff interviewed (director/chief executive officer; manager; clinical leader; care staff including one registered nurse and six healthcare assistants; one diversional therapist; one head chef; one cleaner) were knowledgeable around the Health and Disability Commissioner's Health and Disability Services Consumers' Rights (the Code) and could describe how to apply this as part of their everyday practice.</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 consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on six resident files reviewed (one rest home, two hospital and three dementia). One hospital resident refuses to sign resuscitation consent but has signed a general consent. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. Dementia resident EPOAs have been activated.</p>

<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>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families and is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files included information on resident's family and chosen social networks.</p> <p>The manager has encouraged Age Concern to visit and talk with residents if they have raised issues or wish to talk with an independent person.</p>
<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>	<p>FA</p>	<p>There are no set visiting hours and family reported that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services independently or as part of the planned activities programme. Residents continue to be as independent as possible with activities in the community.</p> <p>Residents in the rest home are identified as being independent and mobile.</p> <p>The service encourages the community to be a part of the residents' lives in the service with visits from entertainers.</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>	<p>FA</p>	<p>Policy and procedures are in line with Right 10 of the Code and identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Complaint forms include contact details for advocacy services. Residents and family confirmed that they are informed by the manager or clinical leader that they can talk with them at any time. Training on the complaints policy and process is part of the staff orientation programme and ongoing education.</p> <p>The complaints register records the complaint and date of resolution with any documentation of the complaint retained in the complaints folder. The complaints register is up to date.</p> <p>There have been two internal complaints since the last audit. All have been investigated and resolved within timeframes documented in policy. Complainants were happy with the outcome. A complaint lodged with the district health board has been investigated and closed out by the district health board with no corrective actions raised. The Ministry of Health requested follow-up against</p>

		aspects of a complaint that included food services, care of a resident in pain, and garden areas. This audit has identified issues with food services (link 1.3.13).
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service is displayed in the facility including pamphlets available for residents and family in the dementia unit, rest home and hospital. The service provides information on the Code to families and residents on admission.</p> <p>Residents interviewed (three from the rest home and three from the hospital), and family interviewed (two from the hospital and two with family in the dementia unit) stated that they believe their rights were met as per the Code. Information around advocacy services and the Code is discussed with residents and relatives on admission. Residents and relatives interviewed confirmed that the Code and the advocacy services were explained on admission.</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>There are a range of policies and procedures to ensure residents are treated with respect. Staff endeavour to maximise residents' independence by encouraging them to actively engage in cares and to continue to access the community as long as possible. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit.</p> <p>The service ensures that each resident has the right to privacy and dignity. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Staff reported that they knock on bedroom doors prior to entering rooms and ensure doors are closed when cares are being completed as observed on the day of audit. Verbal handovers and personal discussions are held in private areas as observed during the audit. Residents and families confirmed that physical privacy is respected.</p> <p>Staff stated that they are committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training annually on abuse and neglect and can describe signs and reporting requirements. Residents personal belongings are not used for communal use. The general practitioner stated that there was no evidence of abuse or neglect. Residents and family interviewed stated that there was no evidence of abuse or neglect. One complaint around alleged abuse was thoroughly investigated with immediate corrective actions taken to resolve the issue. The complainant was satisfied with the outcome.</p> <p>There are quiet, low stimulus areas that provide privacy for residents in the dementia unit.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff when supporting residents who identify as Māori. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection and participation.</p> <p>Staff interviewed confirmed an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training.</p> <p>Staff interviewed described how they asked residents and family who identify as Māori, to describe what their needs are. One record for a resident who identifies as Māori was reviewed and this identified the resident's cultural needs in the care plan and activity plan.</p> <p>Access to Māori support and advocacy services are available through the DHB if required. The director/chief executive officer is of Māori descent and can actively support residents of Māori culture.</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>	FA	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirmed their understanding of cultural safety in relation to care. Residents and family members interviewed confirmed that staff respect their values and beliefs.</p> <p>Care staff interviewed could describe how they communicate by using signs and body language for residents who have difficulty communicating due to dementia, or residents who have English as a second language. This includes use of family to interpret and use of body language and observation and interpretation of resident body language and use of music in their language. Interpreting services are available. A number of staff also have a second language and communicate to residents if required in their own language.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in policy and job descriptions. Staff sign a confidentiality clause and house rules on employment.</p> <p>Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the care partner role and responsibilities.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There are policies and procedures to guide practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external aged care consultant. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice with this able to be described by clinical staff.</p> <p>The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery.</p> <p>Family members interviewed confirmed they are satisfied with the care provided. Residents were satisfied with most aspects of care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There are policies covering communication with residents/relatives, and management interviewed, reported that they have an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents can discuss issues at any time with staff.</p> <p>The incident and accident forms include an area to document if the relatives have been contacted. Ten incident forms reviewed identified family were informed where required. Open disclosure is practised and documented when family are contacted. The general practitioner interviewed, reported satisfaction with communication from staff.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Cromwell House and Hospital is certified to provide rest home, dementia level care and hospital (geriatric and medical) for up to 52 residents. As part of this audit a single room was verified as being able to accommodate two residents (hospital or rest home level) in one room at this audit. The Ministry of Health had given approval for the room to be in use from the 16 June 2020 with verification at this audit.</p> <p>Of the 52 beds identified as being certified, five are identified as being rest home beds only; 22 identified as being for residents with dementia requiring a secure unit and 25 as available for residents requiring hospital (dual purpose) level of care. On the days of the audit, there were 40 residents including five requiring rest home level of care (including one resident funded under the long-term support – chronic health conditions contract); 21 requiring hospital level of care (including one resident funded under the long-term support – chronic health conditions contract (e, LTS-CHC contract and one resident under 65 years of age); and 14 requiring dementia level of care (including one under a respite contract). There were no residents under the primary options acute care</p>

		<p>(POAC) contract.</p> <p>Cromwell House and Hospital is owner/operated by three directors who maintain regular contact. One of the directors is referred to as the director/chief executive officer and they take responsibility for maintenance. They have a master's degree in technology and is a registered plumber. The director/chief executive officer lives on site and staff are able to ask for assistance if required during the night shift. The manager (director) is a registered nurse and is on site seven days a week. A third director is not actively engaged in the day to day operations of Cromwell House and Hospital. The owners took over on 8 October 2019.</p> <p>The mission statement and philosophy of care are documented and given to any potential or new resident and/or family on admission to the service as part of the welcome pack. The 2019 business plan and goals have been reviewed. Goals for 2020 are documented. The owner/directors liaise with an employment law firm, health and safety advisor and are members of an aged care association with opportunities to attend conferences and provider meetings.</p> <p>The directors have owned a 56-bed rest home and hospital in close proximity to Cromwell House and Hospital and the manager of Cromwell House and Hospital has been a facility manager at the other site for the last two years. The manager attends the Aged Related Care forums and cluster meetings at the district health board.</p> <p>The clinical leader at Cromwell House and Hospital has been in the service for 22 years and has extensive experience in overall clinical and operational management. They have maintained relevant professional development hours. There has been a section 31 notification for the change in clinical manager.</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>	<p>FA</p>	<p>During the temporary absence of the manager, the clinical leader is able to take responsibility for the service and provide both clinical and operational management. The manager is a registered nurse and is able to provide cover for the clinical leader when on leave. The manager and clinical leader share the on-call.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	<p>PA Low</p>	<p>There is a quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to review by the external aged care consultant, with input from the manager and clinical leader. Policies are linked to the Health and Disability Sector Standards, current and applicable</p>



<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>legislation, and evidenced-based best practice guidelines. Policies are available to staff in hard copy. A document control system is implemented, and this ensures that documents are approved, up-to-date, and managed to preclude the use of obsolete documents.</p> <p>Service delivery is monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any pressure injuries; feedback from residents and family and implementation of an internal audit programme. The internal audit schedule is documented annually with audits completed as per schedule. Corrective action plans have been developed for results less than expected and signed off when completed.</p> <p>The schedule of quality/staff and registered nurse meetings allows for discussion and review of data; however, meeting minutes do not always confirm resolution of issues raised. Staff reported that they are kept informed of quality improvement and risk management through meetings. Resident meetings are held three monthly to allow for discussion around quality improvement data. A survey was last completed in 2019 prior to the new owners taking over. A questionnaire is being circulated to residents and family currently.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise, and risks are eliminated, minimised or isolated. Health and safety is audited monthly. Review of incidents, risks, accidents, and clinical issues are discussed through quality/staff meetings as part of the health and safety programme.</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>	<p>FA</p>	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported with these signed off by the manager or clinical leader.</p> <p>Ten incident forms were reviewed, and these showed evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner when incidents occur. Both family and the general practitioner interviewed confirmed that incidents are reported in a timely manner. The sample confirmed that incidents and accidents are closed following review and linked to the quality system with documentation of data at relevant meetings. Neurological observations are documented for a fall with a head injury or an unwitnessed fall.</p> <p>The manager could describe the statutory and/or regulatory obligations in relation to essential notification reporting and could describe the process of notification to the correct authority where</p>

		required. Three section 31 notifications have been sent to HealthCERT for pressure injuries.
<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>There is an established system in place for human resource management. Staff records reviewed (clinical leader, two registered nurses, two healthcare assistants - shift team leaders, and one diversional therapist) included an employment agreement and a position description. Reference checks are completed for new staff. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation with a record of this maintained on staff files reviewed. The orientation programme covers key aspects of the organisation and service delivery including special care requirements for hospital, dementia, and rest home levels of care. Two new care staff were interviewed, and both stated that they had completed a comprehensive orientation with a buddy system operating. There is a schedule for staff annual performance appraisals, and all appraisals have been completed as scheduled.</p> <p>The 2020 training plan is implemented with a high number of care staff attending training sessions. The physiotherapist provides safe manual handling sessions. Staff complete competencies relevant to their role such as fire safety, infection control, restraint, challenging behaviour and medications.</p> <p>There are nine healthcare assistants who work in the dementia unit. Seven have completed training in dementia care and two are in training. There are two international trained registered nurses with level 7 diploma in management as well as training in dementia care. A review of rosters for the past three months confirmed that there was always an HCA trained in dementia care on duty in the dementia unit.</p> <p>All four registered nurses and the clinical leader, clinical coordinator and manager are interRAI trained.</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>	PA Moderate	<p>The process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided. Staff rosters are developed by the clinical leader. The service uses bureau or existing staff to relieve for staff who are on leave. Rosters reviewed confirmed that staff are replaced when on leave.</p> <p>The manager and clinical leader share the on call after hours. Staff stated that on call staff respond promptly. The manager and clinical leader are currently working as rostered registered nurses. Registered nurses work either an 8-hour shift or 12-hour shifts to cover the 24-hour RN on duty.</p> <p>Healthcare assistants are allocated to each area. The dementia unit is staffed by two HCAs 6 am to 2 pm; two HCAs from 2 pm to 10 pm and one HCA overnight (from 10 pm to 6 am). The healthcare assistants in the dementia unit also provide care and support for the residents in the five rest home</p>

		<p>beds that are in the same building as the dementia unit (noting that they are not part of the secure unit).</p> <p>There are four healthcare assistants in the hospital building from 6 am to 2 pm; two healthcare assistants from 2 pm to 10 pm and one from 10 pm to 6 am.</p> <p>The registered nurse is rostered to work in the hospital unit and completes resident rounds of the dementia unit and rest home each shift, sees residents of concern and attends handovers. The registered nurse overnight, completes hourly intentional rounding, noting that the hospital and dementia/rest home units are in separate buildings.</p> <p>A diversional therapist is based in the dementia unit (refer 1.3.7). There are cleaning staff employed.</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>	FA	<p>Resident records are integrated. Resident records in use are maintained confidentially with these locked in a secure area when not in use. Progress records are documented by the care staff in the paper-based record. The date, time, signatures, and designation of those entering into the records is legible.</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>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the Age-Related Care Contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated. The respite resident had a signed short-term admission agreement.</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>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the CMDHB 'yellow envelope transfer system'. Communication with family is made at any point of transfer, exit, discharge, or transition.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. RNs and medication competent HCAs administer medications. Staff attend annual education and have an annual medication competency completed. Two RNs are syringe driver trained by the hospice staff. The medication fridge and room temperatures are checked weekly and are within appropriate range as per policy. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Fourteen medication charts were reviewed (six hospital, two rest home and six dementia). Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted. The respite resident had a medication chart in place. Appropriate practice was demonstrated on the witnessed medication around.</p> <p>All medications are stored safely in the main medication room in the hospital and in locked cupboards in the dementia unit nurses' station.</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>PA Low</p>	<p>The service has one head chef and one cook who cover Monday to Sunday. There are three kitchen assistants who cover mornings, afternoon, and weekends. Both the head chef and the cook have current food safety certificates. The kitchen assistants have had internal training on food safety. The head chef oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen and all meals are cooked on site. Meals are served in each area from either the kitchen or hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be well presented. Some residents and a family member complained that the food was cold most of the time. There is an annual food satisfaction survey that was completed prior to the new owners taking over the service.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly and are within normal range as per policy. Food temperatures are checked, and these were all within safe limits.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated</p>

		<p>to the kitchen. Special diets and likes and dislikes were noted. The four weekly menu cycle is approved by a dietitian. Some residents complained that the food was tasteless. Snacks are available at all times.</p> <p>The food control plan was verified on 30 July 2020.</p>
<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>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</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>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) pain, nutrition, falls risk and pressure injury risk.</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>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse, dietitian, and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet</p>	FA	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p>

<p>their assessed needs and desired outcomes.</p>		<p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there is a 'knock' to the head or for an unwitnessed fall.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently two wounds being treated and there are currently two stage two pressure injuries (one non-facility acquired).</p> <p>Pain assessments are completed for those residents with chronic pain. The RNs report to the GP on pain management so changes to medication for pain can be made if required. The GP liaises with the DHB and/or hospice when appropriate.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</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>	<p>FA</p>	<p>There is one diversional therapist who works forty hours a week. On the day of audit residents were observed playing a balloon game, exercising, and listening to a book reading.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Rest home residents are invited to join the dementia and hospital programme. Individualised programmes are implemented as per resident choice. Residents have the choice of a variety of activities including exercises, games, newspaper readings, music and walks in the garden. Happy hour is held twice a week. The dementia programme is well tailored to the dementia residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are no church services but a Roman Catholic priest visits weekly to give communion. Many residents who are able, go out to church services on a Sunday.</p> <p>There is a van outing twice weekly. Special events like birthdays, Easter, Mothers' Day, Anzac Day, and the Melbourne Cup are celebrated. There is entertainment twice weekly. There is community input from the local schools, dance groups and a Chinese children's' orchestra. Those able, go out shopping and to cafés.</p> <p>There is a Cromwell House cat and the manager's dog comes in on a daily basis.</p> <p>The resident identified as a young person with a disability has a staff member allocated to take the resident out three times a week. The resident likes shopping, cafés and movies.</p>

		Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All long-term plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, general practitioner, and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan. Individual activities plans are evaluated six monthly.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people, the dietitian, and the pain clinic. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The building holds a current warrant of fitness which expires 17 November 2020. The director/CEO is a certified plumber and builder and assists with all maintenance. There is an assistant maintenance staff member who is shared with another facility. There is a part-time gardener. A contracted electrician is available when required.

<p>for their purpose.</p>		<p>Electrical equipment has been tested and tagged and medical equipment calibrated annually as per schedule. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. The dementia unit has a fenced off garden.</p> <p>The facility has recently converted an office to a shared bedroom. This is approved as being suitable for use by two rest home or hospital residents noting that curtains are will be installed if there is more than one resident. Currently the room is only used by a single resident.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care to residents in the rest home, hospital, and dementia unit.</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>	<p>FA</p>	<p>In the rest home and hospital all rooms have hand basins. In the dementia unit only nine rooms have hand basins. Two rooms share a toilet and shower. All the rest share communal toilets and showers. Fixtures, fittings, and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors that denote vacant or in use.</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>	<p>FA</p>	<p>There are currently two shared bedrooms. These have 'dividing' curtain tracks up. One of the shared rooms has no dividing curtains up as the residents requested dividing screens instead. These were sighted in the room. All other rooms are single.</p> <p>There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And</p>	<p>PA Low</p>	<p>In the hospital and dementia unit here are large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may</p>



<p>Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>sit. The dining room in the dementia unit is spacious. The hospital sets up tables in the lounge area for residents who use tables, however most are fed in fall-out chairs appropriate to their needs. This works as there are a large percentage of residents who need to be fed by staff.</p> <p>In the rest home there is no dining room or lounge, and residents are asked by staff to use the lounge or dining room in the dementia unit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done off site. Cleaning services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There are two sluice rooms on each floor for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms are kept closed when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an approved evacuation scheme. Evacuation drills occur at least six monthly, with the results of these documented. There is a staff member on duty 24/7 with a current first aid certificate.</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare batteries for lights, a gas barbecue, linen, continence products, torches and batteries, water, and blankets. Food dry stock and frozen food are available to support residents for at least three days. There is enough drinking water on site to support the maximum number of residents on site for three plus days.</p> <p>A modern call bell system was installed May 2019 in all resident rooms, communal areas, and toilet/shower facilities. The call bell system is monitored by the company and has an emergency battery backup of six hours. Call bells across the two buildings (including rest home/dementia unit and hospital) can be heard throughout the facility. The registered nurses have a mobile phone.</p> <p>Closed circuit television has been installed in hallways and main areas such as lounges and dining areas. These can be monitored to ensure safety of residents. The manager stated that information is only used to ensure that residents are safe. The two entrances to the dementia unit are secured with keypad entry. A perimeter fence around the dementia unit with locked gates ensures residents are kept safe.</p> <p>Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately. The upstairs external door is kept locked during the day and residents are accompanied in the external lift to the main hospital</p>

		<p>communal areas.</p> <p>External doors are locked in the evening. There is external lighting and there is a sensor gate across the driveway to the facility.</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 bedrooms and communal areas have ample natural light and ventilation. The hospital has gas central heating and the dementia unit and rest home have radiators. Staff and residents interviewed stated that this is effective. All indoor areas are smoke free and there is a designated smoking area outside for residents who wish to smoke.</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>There are clear policies and procedures for infection, prevention and control which minimises any risk of infection to residents, staff, and visitors. Infection control management is appropriate to the size and scope of the facility.</p> <p>There is an infection control coordinator (clinical nurse leader) who is responsible for infection control across the facility. The coordinator liaises with and reports to the manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the manager.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.</p> <p>There are clear guidelines for staff and residents around Covid 19. Changes are communicated to staff at handovers and through written news bulletins. Staff have to sign when they have read the bulletins.</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</p>	FA	<p>The IC coordinator is a very experienced registered nurse and they have access to infection control expertise within the district health board. This includes access to the wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.</p>

the organisation.		
<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 control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed by an external infection control specialist.</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>The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there is more training planned for 2020. There was particular emphasis on hygiene and personal protective equipment (PPE) during Covid 19 lockdown. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</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 infection control coordinator is responsible for the surveillance programme of infections. Standard definitions, types of infections are documented to guide staff. Information is collated monthly and clearly documented in the infection log maintained by the infection control coordinator. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Infections are investigated, and appropriate plans of action were sighted in meeting minutes. The surveillance results, trends and analysis are discussed at the staff and registered nurse meetings. Monthly data is benchmarked (by the aged care consultant) with reports and graphs generated for the service. Infection control data is discussed with management and staff. Corrective actions are developed for any areas of concern. The outcomes of surveillance are used to identify areas for improvement and training needs for the service. Internal audits have been conducted and included hand hygiene and infection control practices.</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Cromwell House and Hospital has policies and procedures around restraint minimisation and safe practice that have been developed by an aged care consultant and reviewed in line with the policy. Care staff interviewed stated that there is a focus on minimising the use of restraint. There were no residents using restraints. One resident had requested the use of bedrails and this was documented as an enabler.</p> <p>Staff receive training on restraint minimisation and safe practice and complete competency questionnaires. The aged care consultant provided training on challenging behaviours in June 2019 and there has been further training for staff in 2020.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed</p>	PA Low	The internal audit reports include corrective action planning which shows evidence of resolution of issues when required. The staff and registered nurse meeting minutes do not always show evidence of resolution of issues.	The staff and registered nurse meeting minutes do not always show evidence of resolution of issues when corrective actions are documented.	Ensure that any corrective actions documented in staff and registered nurse meeting minutes evidence resolution of issues.

and implemented.				180 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Moderate	<p>The dementia unit is staffed by two HCAs from 6 am to 10 pm. The healthcare assistants in the dementia unit also provide care and support for the residents in the five rest home beds that are in the same building as the dementia unit (noting that they are not part of the secure unit but are in the same building). The manager stated that when there is only one healthcare assistant on duty in the dementia unit, they are expected to wake the director/chief executive officer who sleeps in a room in the dementia unit prior to attending to the call bell. This potentially could delay the response to the resident ringing from the rest home and healthcare assistants interviewed from the dementia unit stated that they do not wake the director/chief executive officer as calls are generally quick. This means that the dementia unit is left unattended during that time. Healthcare assistants stated that at times they have answered call bells in the rest home while residents have been awake and up in the dementia unit however, they stated that they are only gone for a short time. Three residents in the rest home interviewed stated that they did not often see healthcare assistants or other staff for meaningful interactions but do see them when they drop off meals on trays to their rooms. The residents also stated that they have often had to wait until mid-afternoon for their bed to be made and toilet/shower cleaned.</p>	<p>Review staffing roles and arrangements for residents in the rest home area to ensure that their needs are provided for and to ensure safety of residents in the dementia unit.</p>	<p>Provide adequate staffing for residents in the rest home area.</p> <p>30 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer</p>	PA Low	<p>Food temperatures are checked before the food is served. Food is either served in the kitchen or from hot boxes. The menu plan has been approved by a dietitian. The kitchen staff are notified of residents' dietary needs and likes and dislikes. Residents and family complained of cold food and that food was tasteless. One resident has a microwave in their room and stated that they always have to heat their meals before eating.</p>	<p>(i) Two rest home residents, three hospital residents and one family member complained that the food was cold most of the time.</p> <p>(ii) Four out of six residents interviewed</p>	<p>(i)-(ii) Ensure resident concerns regarding the meals provided are addressed.</p> <p>90 days</p>

group.			complained that the food was tasteless.	
<p>Criterion 1.4.5.1</p> <p>Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.</p>	PA Low	<p>There is adequate access to lounges and dining rooms in both the hospital and dementia unit. Both areas meet the needs of consumers. The rest home residents have access to an open reception desk and small space that has three lounge chairs, a reception desk, and a computer. There is no TV and no tables for activities or to have meals on. Residents stated that they are required to eat their meals in their rooms. Staff stated that there is a specific time for residents in the rest home to use the dementia unit dining room for their meals and residents in the dementia unit are not able to access the dining area at this time. The hospital building is separated by a covered outdoor walkway and an upstairs covered walkway from the dementia and rest home area.</p> <p>Since the draft report the provider has stated; The shared dining room between dementia and rest home residents has been approved by ADHB quality manager. The dining room in the dementia building is for all the residents to share. If the rest home residents want, they may access 24/7 with the code which they have been given. There is a doorbell outside the door for the rest home residents to use if they are not competent to be given the combine code. The dementia residents use the dining room for breakfast, lunch and dinner. Even during their meal time, the rest home residents still may join if they want. But if they don't want share with the dementia residents there, they may use any time before/after dementia residents time slot.</p>	Residents in the rest home do not have access to their own dining room or lounge area that would meet their needs.	<p>Ensure rest home residents are provided with access to a dining room and lounge which meets their needs for meals, relaxation, and activities.</p> <p>180 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.