

Metlifecare Limited - Crestwood

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Metlifecare Limited

Premises audited: Metlifecare Crestwood

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 27 August 2019 End date: 27 August 2019

Proposed changes to current services (if any): The facility wishes to reconfigure services to enable all 41 beds to become hospital level care as well as rest home (dual purpose).

Total beds occupied across all premises included in the audit on the first day of the audit: 39

Executive summary of the audit

Introduction

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

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

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
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

Metlifecare Crestwood currently provides rest home level care for up to 41 residents. The service is operated by Metlifecare Limited and managed by a nurse manager who reports directly to the village manager who oversees all services including the attached village. Residents and families spoke positively about the care provided.

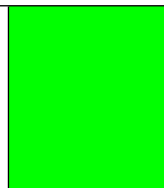
The service has made an application to reconfigure their services from being solely rest home level care to include hospital level care and to use all 41 beds as dual purpose beds.

This surveillance/partial provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a nurse practitioner.

This audit identified one area requiring improvement relating to gaining registered nurse coverage for 24 hours a day, seven days a week prior to hospital level care services being made available. There were no areas identified that required follow up from the previous audit.

Consumer rights

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



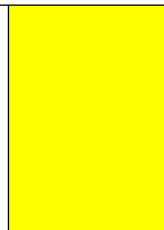
Standards applicable to this service fully attained.

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

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of low risk.

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

The 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 families. 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.

Currently, staffing levels and skill mix meet the changing needs of rest home level care residents.

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.
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Residents of Metlifecare Limited Crestwood have their needs assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

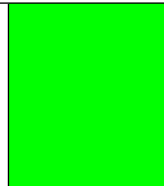
The planned activity programme is overseen by three activities co-ordinators and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

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

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and biomedical 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. There is adequate equipment to cater for hospital level care residents.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness. The laundry staff have no concerns about the increase of laundry once hospital level care is introduced as they have adequate equipment to cater for this.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. As there will be no reconfiguration of rooms, no changes are required to the current fire evacuation processes. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support a restraint free environment. No restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process is identified in policy should it be required. 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 processes.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from an external advisory company and the organisation's clinical advisory group. The programme is reviewed annually.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	24	0	1	0	0	0
Criteria	0	58	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and feedback forms are located in the main corridor. Residents and family members who were interviewed knew where to locate forms and understood how to make a complaint.</p> <p>The complaints register reviewed showed that two complaints have been received over the past year. Both complaints have documented actions taken, one through to an agreed resolution, within the timeframes. Action plans showed any required follow up and improvements have been made where possible. One complaint received from the Waitemata District Board (WDHB), received in May 2019 via the WDHBs internal incident reporting and management system, involved a resident from Crestwood who was admitted at Waitakere Hospital. The incident was entered by Waitakere emergency department staff. The areas of concern were around the quality of care provided to this resident in relation to her personal hygiene, skin and pressure area care, and continence management. All areas of concern were fully addressed, and documentation has been sent to the WDHB. The facility is awaiting the outcome of the information sent. The DHB is currently investigating this incident.</p> <p>The nurse manager is responsible for complaints management and follow up. All complaints are entered in the Metlifecare electronic system and complaints management is overseen by the clinical and risk quality manager for the area. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning and care planning review process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via Interpreting New Zealand when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, and reported against quarterly, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of quarterly reports that are sent to the clinical governance group who then report to the board of directors showed adequate information to monitor performance is reported including staffing, quality data outcomes, emerging risks and issues.</p> <p>The service is managed by a nurse manager (registered nurse) who holds relevant qualifications and has been in the role for 18 months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager reports directly to the village manager who has been in the role for two years. Both the nurse manager and the clinical quality and risk manager confirmed their knowledge of the sector, regulatory and reporting requirements. Management qualifications are maintained through ongoing clinical and management education, training and seminars.</p> <p>The service holds contracts with WDHB for rest home level care including respite care. All 39 residents were receiving services under the Age Related Residential Care contract at the time of audit. The WDHB confirmed their awareness of the facility's intention to reconfigure services (March 2019).</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</p>	FA	<p>When the village manager is absent, the operations manager and nurse manager carry out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen using a 'cluster approach' by ensuring appropriate clinical oversight is in place. This involves registered nurses from near-by facilities owned by Metlifecare assisting with staff coverage. They are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. No changes are required to this system related to the request to reconfigure services to provide both hospital and rest home level care.</p>

<p>effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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>	<p>FA</p>	<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, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections falls, and pressure injuries.</p> <p>The service contributes quality data information into a recently formed benchmarking group involving six age care provider groups, with Metlifecare being one. This data covers falls, pressure injuries, medication errors, and restraint. It has yet to be fully evaluated. Infection control data is also benchmarked by an off-site group.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, quality and risk team meetings, senior clinical management meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The 2019 overall satisfaction feedback from the satisfaction surveys gained a 90% rating with the care topic rating 100%. Corrective actions are documented to address areas raised in the satisfaction surveys which included activities which gained an 87% rating. Interventions that have occurred to date are the increase in activity staff hours, an updated activities calendar being put in place which includes items such as swimming and more physical activities. The outcomes are yet to be measured overall but the uptake for all interventions have been measured and identify that more residents are engaging in meaningful activities. The corrective actions put around the 2018 satisfaction survey showed that improvements had been made and fully evaluated such as food services rating going from 83% in 2018 to 97% in 2019.</p> <p>Policies reviewed covered 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 and a suitable for hospital level care and medical (non-acute) care. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. 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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form and reported each event via an electronic reporting system so that the clinical quality and risk managers have real-time access and can assist with follow up as required. A sample of incidents forms 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 to senior clinical management, the nurse manager, village manager and shared with staff and residents as appropriate. Nominated enduring power of attorney or next of kin are informed of any event involving their relative.</p> <p>The nurse manager is aware of essential notification reporting requirements, including for pressure injuries. The clinical quality and risk manager undertakes all reporting requirements and they advised there have been three notifications of significant events made to the Ministry of Health, since the previous audit. One 16 April 2018 for a grade three pressure injury which is now healed, one on 06 November 2018 when a relative removed a resident, and one on 10 June 2019 related to a missing resident who was found uninjured.</p> <p>There have been no police investigations, coroner's inquests, issues-based audits and any other notifications such as to public health.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. At the time of audit there was only one trained and competent registered nurse who had maintained their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for interRAI. The nurse manager is also interRAI trained but has yet to complete the required annual update. The clinical quality and risk manager stated that this is not an issue as interRAI trained staff from a sister-site are available to assist if required. All interRAI assessments were up to date.</p> <p>Partial Provisional – Processes in place will be maintained for all new staff. Staff orientation and education is suitable for hospital level care provision.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. 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. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p> <p>Partial Provisional- A projected roster is in place which shows that there will be 24 hour/seven days a week (24/7) RN coverage when hospital level care commences. The service will require that there are adequate numbers of registered nurses employed to cover all shifts prior to commencing hospital level care services.</p> <p>Activities are undertaken from 9am to 4.30pm Monday to Friday and 12.30pm to 3.30pm Saturday and Sunday. Laundry staff work 9am to 1.30pm Monday to Friday and one staff member works 8am to 12md Saturday and Sunday covering laundry and cleaning. Cleaning is undertaken 13 hours a day Monday to Friday. An administration assistant works 10am to 3pm three days a week. The nurse manager, registered nurse and village manager work Monday to Friday and on call.</p> <p>The kitchen, gardening and maintenance staff are employed by the village with appointed shared time for the care unit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy at Crestwood 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 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 Crestwood in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the</p>

		<p>recommended range.</p> <p>Good prescribing practices noted include the prescriber's electronic authorisation and the date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were two residents at Crestwood who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and nurse manager (NM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Crestwood.</p> <p>Partial Provisional Audit:</p> <p>No changes to the medication management system will be required if the proposed reconfiguration of services goes ahead.</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>The food services at Crestwood are provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in June 2019. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Auckland Council. A verification audit of the food control plan was undertaken on 13 July 2018. No corrective actions were identified. An 'A grade' rating of the food control plan expires 11 January 2020. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook 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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p>

		<p>Partial Provisional Audit:</p> <p>No changes to the kitchen or food service will be required if the proposed reconfiguration of services goes ahead.</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 of Crestwood was consistent with their needs, goals and the plan of care. The attention to meeting a range of resident's individualised needs was evident. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. A review of the wound management folder identified two wounds that were the result of long-standing skin lesions. No skin tears were evidenced to have occurred at Crestwood in recent months and there were no residents with pressure injuries.</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 three activities coordinators, all in the process of training to gain qualifications in diversional therapy.</p> <p>The activities programme at Crestwood operates seven days a week. A recent family satisfaction survey identified some dissatisfaction with the activities programme being offered. A corrective action was put in place that increased the selection and array of activities being provided. The options also now include opportunities for the residents to go swimming in the village pool, access to the gym and access to the bowling green</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted, matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included 'move and groove', visiting entertainers, quiz sessions, visits by the local kindergarten, knitting and craft groups, shopping trips and daily news updates. The residents are also able to participate in events in the village.</p> <p>The activities programme is discussed at the residents' meetings and minutes indicate residents' input is sought and responded to. Residents and family members interviewed confirmed they find the programme meets their needs.</p>
Standard 1.3.8:	FA	Resident care at Crestwood is evaluated on each shift and reported in the progress notes. If any change is noted, it

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>The existing system will remain in place for the reconfiguration of service but if more frequent waste pickups are required this will be implemented.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 28 October 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. There is adequate lifting and biomedical equipment to safely manage hospital level care residents.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. They are easy access for walking frames and wheelchairs if required. Residents have a choice of three internal decked outdoor areas and the main garden area.</p> <p>Staff and residents confirmed if any repairs or maintenance is required, requests are appropriately actioned and that</p>

		they are happy with the environment.
<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. This includes 17 bedrooms with toilet ensembles. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water temperature checking is maintained throughout the care unit to ensure it remains within the required limits.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. All bedroom doors are wide enough to allow a bed and/or lifting equipment to be moved in and out of the room safely.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are</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. Residents can also use the serviced apartment dining room if they wish. Activities were undertaken in the large lounge on the day of audit. As there will be no increase in the resident numbers all areas are adequate to meet the reconfiguration request for dual purpose.</p>

<p>provided with 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 a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The clinical quality and risk manager stated that laundry staff hours will be reviewed regularly to ensure they are sufficient to manage hospital level care resident requirements.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. As there will be no increase in resident numbers the cleaning hours will remain the same.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and by the chemical provider.</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 Ministry of Civil Defence and Emergency Management recommendations for the region are met related to appropriate stocks of water and food. There are also adequate supplies of blankets, mobile phones, alternative cooking such as gas BBQ if required for use in the event of a civil defence emergency. Stocks sighted meet the requirements for the 41 residents. A water storage tank is located on the grounds of the complex.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service in September 2001 and there have been no changes to the footprint since this time.</p> <p>A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 22 May 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. No changes are required for the reconfiguration of services.</p> <p>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>

		Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and there is a night porter who patrols the grounds and checks the security of the buildings seven nights a week.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and four bedroom have ranch slider doors with direct access to the gardens. Heating is provided by ceiling heating and individual electric heaters in residents' rooms with underfloor heating in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are 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>Crestwood provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level. The IPC programme is reviewed annually.</p> <p>An RN from Crestwood is the designated IPC nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the NM, and tabled at the staff meeting. An infection control committee meets quarterly, to discuss any infection related concerns. The committee includes the village manager, NM, IPC nurse, the health and safety officer and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p> <p>Partial Provisional Audit:</p> <p>The present infection control management programme would require no changes if the planned reconfiguration goes ahead.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICN and NM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Infection statistics are entered into the organisations database and benchmarked with the organisations other facilities in addition to other large aged care providers in New Zealand. Results of benchmarking indicate a below average infection rate at Crestwood. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>There have been no outbreaks of norovirus at Crestwood in the past year.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility is restraint free. The restraint coordinator (nurse manager) provides support and oversight for enabler and restraint management and education in the facility. She demonstrated a sound understanding of the organisation's policies, procedures and her role and responsibilities should restraint ever be implemented.</p> <p>Policy states that enablers must be the least restrictive and used voluntarily at the resident's request.</p> <p>The nurse manager reported that restraint would only be used as a last resort when all alternatives have been explored. This was confirmed in meeting minutes reviewed, during staff interviews, on review of the restraint register and the benchmarking data sighted.</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 1.2.8.1</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 Low	<p>The service implements a documented process which determines service provider levels and skill mix. The current rosters identify that adequate staff are available to meet rest home level care resident needs. This includes registered nurse cover for five morning and five afternoon shifts.</p> <p>Partial provisional- There are currently not adequate registered nurses to cover 24 hour, seven day a week duties. The projected roster sighted identifies that this will occur prior to the service commencing.</p>	<p>The current level of registered nurse cover does not meet the required 24 hour, seven day a week coverage required for hospital level care.</p>	<p>Provide evidence that there is 24 hour, seven day a week registered nurse coverage to meet hospital level care contractual requirements.</p> <p>Prior to occupancy days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.