

Cromwell Business Limited - Cromwell House and Hospital

Introduction

This report records the results of a Provisional 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 - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 September 2019 End date: 3 September 2019
Proposed changes to current services (if any):	The service is also certified for hospital – medical level care. This is not included in the table above.
Total beds occupied across all premises included in the audit on the first day of the audit:	37

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.

General overview of the audit

Cromwell House provides hospital (geriatric and medical), rest home and dementia level care for up to 50 residents. On the day of the audit there were 37 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owner. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff and management.

The current owner/director is supported by a clinical manager, administrator, stable and long-serving registered nurses, care partners and diversional therapist. Residents and family interviewed commented positively on the service they receive.

The prospective owners are shareholders in a local hospital and rest home facility. One of the prospective owners is a registered nurse and the facility and clinical manager of their current facility. The prospective owners reported their current policies and

systems will be transferred to the new facility. The registered nurse/owner will be the facility manager across both facilities. The current executive office/administrator will continue to provide support to the new owner for one month following purchase.

Areas for improvement identified at this provisional audit included performance appraisals and aspects around care plans.

Consumer rights

Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). 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.

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.

Organisational management

The service is owned and operated by three directors. A business plan includes the vision, values and philosophy of care. The clinical manager is a registered nurse with a current practising certificate.

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.

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

There is an admission package available prior to or on entry to the service. The registered nurse is responsible for each stage of service provision. A registered nurse reviews each resident's needs, outcomes and care plan goals at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent care partners responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three monthly.

A diversional therapist implements activities in the dementia care unit and in the rest home and hospital, and care partners include activities for other residents as part of their role. An occupational therapist/diversional therapist has recently joined the team and will provide two days per week input to the activity programme. The programme includes community visitors and music therapy.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on site by a contracted service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There are nutritious snacks available 24 hours a day.

Safe and appropriate environment

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. The two buildings hold a current warrant of fitness. There is safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised. There are adequate communal shower/toilet facilities with some en-suites.

Laundry services are outsourced. Cleaning services are provided by staff employed by Cromwell House. Systems and supplies are in place for essential, emergency services. There is a staff member with a first aid certificate on duty at all times.

Restraint minimisation and safe practice

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 were no enablers or restraint in use during the audit.

Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A RN/clinical leader is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection prevention and control education. Surveillance data is collected, collated, and discussed in staff and registered nurse meetings. There have been no outbreaks.

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	43	0	1	1	0	0
Criteria	0	90	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: 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. Care staff interviewed (three care partners, one registered nurse, one acting clinical manager and one diversional therapist) 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>The interview with the prospective provider/registered nurse confirmed that she has been the shareholder/facility and clinical manager of a rest home/hospital facility for almost three years and was able to describe application of consumer rights.</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</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Permission granted is also included in the admission agreement. Specific consents are obtained for specific procedures such</p>

<p>choices and give informed consent.</p>		<p>as influenza vaccine. All seven long-term resident files which comprised of two rest home residents (including one resident with a long-term chronic health condition); two dementia care residents; and three hospital residents (including one younger person); contained signed consents and signed admission agreements.</p> <p>A consent form for rest home residents has been developed to enable rest home residents to consent to accessing the dementia unit. The consent states that they are entering a secure area and doors need to be kept securely locked for the safety of the dementia residents. They are also able to participate in some dementia unit activities as appropriate. There is one double room in the hospital that is currently occupied, with one resident. Residents or family give consent for residents to share a room. Family also sign consent for residents in the upstairs level to be transferred from the lift to the hospital communal areas via the external uncovered pathway.</p> <p>Resuscitation status is included in the advance directive document and appropriately signed by the competent resident. Advance directives identifying the resident's wishes for end of life care, including hospitalisation, were available in all long-term resident files. Copies of enduring power of attorney (EPOA) where available, were in the residents' files. The EPOA had been activated for the two long-term dementia care resident's files reviewed.</p> <p>Family and residents interviewed confirmed they have been made aware of consent processes and that appropriate information had been provided.</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. Information on advocacy services 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 include information on resident's</p>

		family and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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>	FA	<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. Complaints forms include contact details for advocacy services. Residents and family confirmed that they are informed by the managers 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 that have been investigated to the satisfaction of the complainant and resolved.</p>
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Information on the Code and the Nationwide Health and Disability

<p>Consumers are informed of their rights.</p>		<p>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. Residents (one from the rest home and one from the hospital), and family (two from the hospital and three from the dementia unit) interviewed, 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>	<p>FA</p>	<p>There are a range of policies and procedures to ensure residents are treated with respect. Staff endeavour to maximise residents' independence by encouraging residents 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 shut when cares are being completed as observed on the day of audit. Verbal handovers and personal discussions are held in private areas. 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.</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>	<p>FA</p>	<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. Two Māori resident files reviewed 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 second shareholder/prospective new owner 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>	<p>FA</p>	<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 flash cards with key words interpreted; use of family to interpret; use of body language and observation and interpretation of resident body language and use of music in their language. Interpreting services are available.</p> <p>The interview with the prospective provider confirmed that they already own an aged care facility and could describe communication with residents of different cultures. The prospective provider speaks a</p>

		second language.
<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 very happy and satisfied with the care provided to their relatives and expressed a satisfaction with the care delivered.</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. Nine incident forms reviewed identified</p>

		<p>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>Six monthly resident meetings have commenced (meeting minutes sighted) and are open to families to attend. All aspects of the service are discussed, and residents are encouraged to participate and provide suggestions for improvement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Cromwell House & Hospital is certified to provide rest home, dementia level care and hospital (geriatric and medical) for up to 50 residents.</p> <p>Of the 50 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 23 as available for residents requiring hospital level of care.</p> <p>On the days of the audit, there were 37 residents including four requiring rest home level of care (including one resident funded under the long-term support – chronic conditions contract); 17 requiring hospital level of care (including one resident funded under the long-term support – chronic conditions contract and one residents under 65 years of age); and 16 requiring dementia level of care. There were no residents under the respite care contract or primary options acute care (POAC) on the day of audit.</p> <p>Cromwell House is owner/operated by three directors who maintain regular contact. One of the directors (present on the days of audit) is actively involved in the service and has daily contact with the management team. 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 2018 business plan and goals have been reviewed. Goals for 2019 include staffing, buildings and legislation and there are action plans 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 previous clinical manager/registered nurse (who was on a fixed term</p>

		<p>contract) has resigned and one of the senior clinical leaders has been in the acting clinical nurse manager role since May 2019. The clinical nurse manager has been at Cromwell House as an RN for 20 years. She has maintained relevant professional development hours. There has been a section 31 notification for the change in clinical manager.</p> <p>The prospective owners (two shareholders) are currently shareholders in a company that owns and operates a local rest home/hospital facility five minutes' drive from Cromwell House. The prospective major shareholder/registered nurse will become facility manager at their current facility and the facility/clinical manager for Cromwell House. There is another clinical manager at their other facility (St Patricks) which will give the manager the flexibility to move between two facilities. The current acting clinical nurse manager at Cromwell will step back to her previous clinical leader role. The second prospective shareholder has a master's degree in technology, is a registered plumber and will have the role of chief executive for Cromwell House.</p> <p>The prospective owner/RN has managed a 56-bed rest home and hospital for the last three years and been the facility manager for the last two years. The prospective owner attends the ARC forums and cluster meetings at the district health board. The DHB are aware of their potential purchase.</p> <p>There is a 2019 business plan which includes a transition plan to ensure a smooth transition during the change of ownership. Both shareholders will take on a consultant/advisor role from 8 September 2019 to enable them to establish a therapeutic relationship with residents and staff until takeover. The executive officer/administrator has agreed to continue working with the new management team for one month after settlement. The intended settlement date is 8 October 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 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 clinical manager, the clinical leaders (two) are available and experienced to cover the service. Both clinical leaders are registered nurses who have been in these positions for several years. The clinical manager and clinical leaders will share the on-call. This will continue with change of owner.</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>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 clinical manager and clinical leader. Policies are linked to the Health and Disability Sector Standards, current and applicable 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. Meeting minutes confirmed that all areas of the quality and risk management programme are discussed including infection control and health and safety. Staff reported that they are kept informed of quality improvement and risk management through meetings. A survey was last completed 2017 and results collated and analysed by an external aged care provider. There was positive feedback with 95% satisfied. The service has now changed to an online survey that residents/relatives can complete at any time throughout the year. There have been no responses to date.</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</p>

		<p>meetings as part of the health and safety programme.</p> <p>The prospective owner engages an aged care consultant to provide and review all policies and procedures that will be transferred across to the new facility.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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 clinical manager or clinical leader.</p> <p>The nine incident forms reviewed 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 clinical 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 required. A section 31 had been sent to HealthCERT for a stage three pressure injury. HealthCERT was notified (section 31) of a sudden death requiring a coroner's investigation which is still open. The service has provided the required documentation.</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>	PA Low	<p>There is an established system in place for human resource management. Staff records reviewed (clinical manager, one RN, four care partners 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</p>

		<p>including special care requirements for hospital, dementia and rest home levels of care. There is a schedule for staff annual performance appraisals, however not all appraisals had been completed as scheduled.</p> <p>The 2019 training plan meets the mandatory requirements. Training has been completed as planned with good staff attendance. 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. All staff are currently completing a service specific orientation with policies and competencies that align with the ARC requirements.</p> <p>There are 19 care partners (caregivers) who work in the dementia unit. There are two international trained RNs with level 7. Ten care partners have completed the dementia unit standards and seven are in the progress of completing their papers with a finishing date in November 2019.</p> <p>All four registered nurses 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>	<p>FA</p>	<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. Rosters and staff interviewed, and observation on the days of audit, confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the contract with the district health board. The service uses bureau to relieve for staff who are on leave. Rosters reviewed confirmed that staff are replaced when on leave.</p> <p>The clinical nurse manager and clinical leader share the on call after hours. Staff stated that on call staff respond promptly. The clinical manager and clinical leader are currently working as rostered RNs. Registered nurses work either an eight-hour shift or 12-hour shifts to cover the 24-hour RN on duty.</p> <p>Care partners (caregivers) are allocated to each area. The dementia unit is staffed by two caregivers 7 am to 7 pm and two eight-hour shifts in the morning; two eight-hour shifts in the afternoon and two caregivers</p>

		<p>at night (one oversees the rest home). There is a care partner on duty in the rest home from 7am to 7pm and another from 2.30 pm to 11 pm. The care partners in the rest home also cover other areas as required following completion of cares for rest home residents.</p> <p>The hospital building is staffed by three care partners from 7 am to 3.30 pm, one care partner from 7 am to 1 pm and one from 7 am to 7 pm; two care partners from 2.30 pm to 11 pm and two care partners overnight.</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. There are cleaning staff employed.</p> <p>The food services are contracted to prepare and cook all meals on site. The laundry goes off site.</p> <p>The prospective owner stated initially there is no intended changes to staff. However, this will be reviewed to determine what extra hours if any are needed. There is the possibility of sharing staff between the two facilities. Several care staff at the other facility have dementia standards qualifications. The prospective new owners will review the contracted services (food services and laundry) in the future.</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>	<p>FA</p>	<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</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Seven long-term admission agreements reviewed aligned with all contractual requirements.</p>

services has been identified.		Exclusions from the service are included in the admission agreement.
<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>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service.</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>	FA	<p>Policies and procedures are in place for safe medicine management that meet legislative requirements. Registered nurses and medication competent care partners who administer medications complete annual medication competencies. Medications (robotic rolls) are checked on delivery by the registered nurses against the medication chart and any discrepancies are fed back to the pharmacy. The robotic roll is signed by the RN to verify reconciliation of medications. All medications were stored safely in the hospital medication room and in dementia unit nurses' station. Standing orders are not used. There were no self-medicating residents on the day of audit. The medication fridge is monitored daily, and temperatures were within the acceptable range. All eye drops were dated on opening. Expiry dates and stock levels of bulk supply orders for hospital residents is checked weekly.</p> <p>Fourteen paper-based medication charts were reviewed. The GP reviews medication charts at least three monthly. All medication charts had photo identification and an allergy status. The administration signing sheets reviewed identified medications had been administered as prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals and baking are prepared and cooked on site by a contracted service. The chef manager is supported by care partners who wash the dishes. The kitchen is adjacent to the dining room in the dementia unit. The kitchen door has a keypad lock and is outside of the secure unit. The servery door slides and locks when not in use.</p>

		<p>Meals are plated and served from the kitchen servery bench to the dementia unit and rest home dining room.</p> <p>The four-week menu has been reviewed by a dietitian. The chef manager receives a nutritional profile for each resident which is updated with any changes. Resident likes, and dislikes are known. Gluten free, modified diets, halal meats and dislikes are accommodated. All meals are plated in the kitchen on to warmed plates, covered and transported by trolley to the hospital unit. There are nutritious snacks available 24 hours for dementia care residents.</p> <p>The food control plan has been verified and expires 30 January 2020. Food services staff received food safety training August 2018. Fridge, freezer and chiller temperatures are monitored and recorded daily. End cooked temperatures are taken on all foods daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained. The chemical provider services the dishwasher monthly. The chef manager receives direct verbal feedback and is attending resident meetings. Feedback from rest home and hospital residents/relatives was variable.</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>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</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>The RNs complete an initial assessment on admission including risk assessments and interRAI assessments as appropriate. InterRAI assessments are utilised six monthly or earlier due to health changes for long-term residents under the ARCC. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the care plan. Behaviour assessments are completed for dementia care residents and the outcomes reflected in the care plan.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Long-term care plans reviewed were individualised, however two of seven long-term care plans did not reflect the resident's current health status and supports required to meet the resident goals. Relatives interviewed confirmed they were involved in the care planning process, but there was no documented evidence of resident/relative involvement in the care plans. Care plans for dementia care residents document management of behaviours which includes activities for the de-escalating of behaviours.</p> <p>Short-term care plans were sighted for wounds and infections. They had been evaluated and either resolved or added to the long-term care plan if an ongoing problem.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, district nurses and speech language therapist.</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>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the progress notes.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound management care plan (including dressing type and evaluations on change of dressings) was in place for one resident with two wounds. The district nurse was providing input. There is access to the DHB wound nurse specialist for advice if required. There was one stage two pressure injury on the day of audit. The registered nurse stated the pressure injury was noticed on return from hospital.</p> <p>Continence products were available. The residents' files included a urinary continence assessment, bowel management plan, and continence products used.</p>

		<p>All falls, witnessed and unwitnessed, were reported and followed up by an RN, neurological observations had been completed for unwitnessed falls. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food and fluids. Behaviour charts were available and used as required.</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>A qualified diversional therapist (DT) is employed Monday to Friday and implements the activities in the dementia care unit from 8 am to 5 pm. An occupational therapist has recently been contracted for two days per week to offer an increase in services enabling hospital residents to receive additional activities.</p> <p>The DT and OT liaise with the care partners in the hospital unit who implement one-on-one and small group activities as part of their role. Rest home residents are more independent. They are invited to attend activities in the dementia and hospital units as they desire for entertainment, music therapy and other activities.</p> <p>The DT (interviewed) contacts rest home residents on his days of work. There are adequate resources for care partners to initiate activities such as board games, music and colouring/drawing. Entertainers visit regularly and there are volunteers involved in activities such as musical activities. The activities in the dementia care unit are flexible and based on residents' preferences/needs on the day.</p> <p>An activity planner displays activities available and daily activities in the dementia unit are displayed on the whiteboard. Activities include (but are not limited to); newspaper reading, balloon games, exercises, dance, discussions and reminiscing, story-reading, garden walks and art sessions. One resident has a cat and is supported to care for the cat. A chaplain visits regularly. A music therapist visits the dementia care residents three times a week and interacted with residents on the day of audit. One-to-one activities include card games, sensory massages, use of photo album and reminiscing.</p> <p>A resident activity assessment is completed on admission. Each resident has an individual activity plan. Monthly progress notes are maintained, and the activity plans are reviewed six monthly at the same</p>

		<p>time as the care plans.</p> <p>Activities for younger residents included one-to-one card games, sensory massages, visual aids including a fish tank and origami.</p> <p>Bus trips for residents occur on the first Thursday of each month, where residents visit sights around Auckland.</p> <p>The service receives feedback on activities through direct contact with residents. Relatives of dementia care residents were happy with the activities provided in the dementia care unit. Feedback from rest home and hospital residents/relatives was variable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six monthly for long-term residents. Two hospital residents had not been at the service for six months. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. There was evidence of referrals for re-assessment of levels of care as required.</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>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. There is a sluice room/cleaners' room in the rest home with a chemical mixing system. The chemicals in the hospital sluice room were kept in a locked cupboard and the door to the sluice room was locked.</p>

		<p>Chemical bottles sighted had correct manufacturer labels. Personal protective clothing was available for staff and was observed being worn by staff as they were carrying out their duties on the day of audit.</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>	<p>FA</p>	<p>There are two separate buildings. The rest home of five beds and the dementia unit of 22 beds are in one building. The hospital building is two levels with six resident rooms upstairs and the remaining beds are on the ground level. There is stair and lift access, the lift exits to the external pathway outside of the hospital building. The main entrance to the hospital and dementia unit are across from each other. Both buildings have a current warrant of fitness that expires 17 November 2019.</p> <p>The service contracts a maintenance person for one to three days a week depending on maintenance requirements. The maintenance person is available at other times as required. There are maintenance request forms for repairs, and these are completed and signed off. The maintenance contractor is certified to complete testing and tagging and calibrations of equipment. Other preferred essential contractors are on call for essential services such as a plumber who completes monthly hot water temperatures. There was evidence that environmental maintenance including painting was being attended to.</p> <p>Since the last audit, the wooden shelves in the kitchen and pantry and pantry floorboards have been replaced. The communal or shared ensuites / toilets have vacant / engaged signs in place. The upstairs bedrooms now have window security stays in place. A policy has been developed to cover off the resident's upstairs. The resident's bedroom opposite the lift exit door is no longer being used as a thoroughfare for transferring residents into the hospital building. The decking boards and ramp at the rest home main entrance have been repaired.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas were accessible. Corridors are wide with handrails in place. There is ramp access to the gardens and grounds. Seating and shade are provided.</p> <p>The dementia unit front entrance and entrance from the rest home has keypad entry and exit. There is free access to the garden and walking</p>

		<p>pathway. The external grounds are secure.</p> <p>The registered nurses interviewed stated they have sufficient equipment including mobility aids, wheelchairs, hoists (standing and sling) hospital lounge chairs and pressure injury resources (if required) to safely deliver the cares as outlined in the residents' care plans.</p> <p>The prospective owners confirmed on interview there will be no environmental changes (apart from ongoing maintenance made during the first year of ownership).</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate communal showers/toilets in each unit. Each room has a hand basin. In the hospital unit there are three rooms with own ensuites, and two rooms share an ensuite. Residents confirmed staff respect their privacy while attending to their hygiene cares.</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>All rooms are single in the rest home and dementia unit. There is one double room in the hospital with a privacy curtain in place. There is adequate room for residents to safely manoeuvre using mobility aids or for staff to safely use a hoist. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the hospital unit includes an open plan main lounge, dining area with doors that open out onto the garden area with ramp access. There is another small lounge/kitchenette area downstairs and one upstairs. The rest home has an open small lounge with TV. The rest home residents dine at a separate time from the dementia residents in the dementia unit dining room. A consent is in place that rest home residents sign stating they are happy to access the secure dementia area. I have attached this. The other alternative is that they could stay in the rest home and have their meals.</p> <p>There are two lounges in the dementia unit which allows for group or individual activities. The smaller lounge has a dining area available. There is a large dining room in the dementia unit where meals are</p>

		served from the kitchen servery.
<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>Laundry and personal clothing are laundered off site at a commercial laundry. Dirty linen is sorted into dirty linen skips and stored in an external shed where it is collected every second day. Linen cupboards viewed on the day of audit evidenced sufficient linen supplies. Clean laundry and personal clothing are delivered in linen bags to the front entrance then distributed to the areas. Care partners fold all clothing and iron as required and have folding tables for this.</p> <p>Cleaners are employed by Cromwell House to undertake the cleaning in the facility. Designated cleaners have well equipped cleaning trolleys and personal protective equipment to carry out their duties. The cleaning trolleys are stored in the sluice room in the hospital and the locked cleaning cupboard in the rest home.</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 has been 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 can be heard throughout the facility.</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 clinical nurse manager stated that information is only used to ensure that residents are safe. The two entrances to the</p>

		<p>dementia unit are secured with keypad entry. A perimeter fence around the dementia unit with locked gates ensures residents are kept safe. 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 communal areas.</p> <p>External doors are locked in the evening. The RNs have a mobile phone, there is external lighting and there is a sensor gate across the driveway to the home. There is CCTV and the entrance</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>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All bedrooms have adequate natural light.</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>Cromwell House has an infection control programme that is reviewed annually. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A senior RN/clinical leader is the designated infection control coordinator. The infection control coordinator is supported by the clinical nurse manager. Infection control is discussed at the staff and clinical meetings. There are sufficient supplies of personal protective equipment and outbreak management resources.</p> <p>Visitors are asked not to visit if unwell. Residents are offered the influenza vaccine. There were hand sanitisers placed throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources in place to implement the infection control programme. The infection control coordinator (clinical leader) had completed an on-line infection control course March 2019. The infection control coordinator reported that they can seek advice from the DHB infection control nurse, gerontology nurse specialist and district nurses when needed. The GP is readily available for advice and monitors the</p>

		use of antibiotics. Hand washing facilities are available throughout the facility and hand sanitiser was freely available. There were also adequate supplies of gloves, continence products and wound care supplies.
<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>Infection control policies and procedures have been developed by an aged care consultant. Staff were familiar with the policies and could describe best practice. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training, and education of staff. The policies have been reviewed annually by the infection control coordinator.</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 infection control coordinator is responsible for coordinating/providing education and training to staff. Infection prevention and control is included in the orientation programme for new staff. Infection control education has been annually. Staff receive topical updates on infection control matters at handovers and staff meetings. Staff also receive one-on-one training as required. Staff complete infection control competencies including hand hygiene.</p> <p>Information is provided to residents and visitors that is appropriate to their needs. Residents are educated in the use of sanitisers and the importance of hand washing.</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</p>

		<p>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 has policies and procedures around restraint minimisation and safe practice that have been developed by an aged care consultant and reviewed March 2019. Care staff interviewed stated that there is a focus on minimising the use of restraint. There were no residents using restraints and no residents with enablers at the time of the audit.</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.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Annual performance appraisals identify staff individual training requirements, areas of strength and areas for improvement. There is a schedule for performance appraisals, however these have not always been completed as scheduled.	Two of seven staff files reviewed did not have annual performance appraisals completed.	<p>Ensure performance appraisals are completed as scheduled.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	Five long-term care plans reflected the outcomes of the interRAI assessments, however long-term care plans for two residents did not document interventions for pain management as identified through the assessment process.	There were no documented interventions/supports for one hospital resident and one dementia care resident with identified pain.	<p>Ensure care plans reflect the outcomes of the interRAI assessments.</p> <p>90 days</p>

<p>Criterion 1.3.5.3 Service delivery plans demonstrate service integration.</p>	<p>PA Low</p>	<p>Relatives interviewed confirmed they had the opportunity to discuss the resident's care plans, however not all care plans had been signed to evidence family input into care planning.</p>	<p>The care plans for three residents (one hospital resident, one rest home resident and one dementia resident) did not evidence any family input into care planning.</p>	<p>Ensure documented evidence of family input into care planning as appropriate.</p> <p>90 days</p>
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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.