

Cromwell Business Limited - Cromwell House and Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:

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| Legal entity: | Cromwell Business Limited |
| Premises audited: | Cromwell House and Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 13 January 2022 End date: 13 January 2022 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 44 |

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 |
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|  | 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 |
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| Yellow | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| Red | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

Cromwell House and Hospital currently provides hospital (geriatric and medical), rest home and dementia level care for up to 52 residents. On the day of the audit there were 44 residents.

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

Operational management of the service is by a manager (director and registered nurse), director (chief executive officer), and a clinical leader (registered nurse).

Four shortfalls identified at the previous certification audit around the quality programme; staffing; food service; and dining and lounge areas for rest home residents have been addressed.

This audit identified one shortfall around neurological observations.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
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The service is owned and operated by three directors. A business plan includes the vision, values, and philosophy of care. The clinical leader is a registered nurse with a current practising certificate who has been working in the aged care area for many years. The team includes directors (two of whom take a hands-on role) along with registered nurses, healthcare assistants, and support staff.

The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

Appropriate employment processes are adhered to. An education and training programme is established. The roster provides sufficient and appropriate staff cover for the effective delivery of care and support.

Continuum of service delivery

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| 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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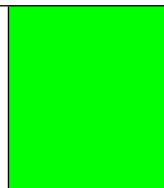
Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident and family/whānau involvement included where appropriate. They are evaluated six-monthly or more frequently when clinically indicated. There are medication policies in place that set the standards for appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner.

A range of individual and group activities are available and coordinated by the diversional therapist.

All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

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.

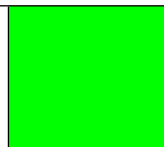


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. External areas are safe and well maintained. Cleaning and laundry services are well monitored through the internal auditing system.

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.

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 is no use of restraint or enablers on the day of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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 | 16 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 41 | 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 |
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| <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>Auditors interviewed the manager (director and registered nurse), the clinical leader and seven staff (two registered nurses, three healthcare assistants [HCAs who worked in all levels of care in the service], the cook and diversional therapist. All were able to describe the complaints process and their role in documenting, escalating and/or managing complaints.</p> <p>Policy and procedures are in line with Right 10 of the Code and identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Complaint forms include contact details for advocacy services. Residents and family confirmed that they are kept informed by the manager or clinical leader. 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 with four complaints documented in 2020, one complaint in 2021 and no complaints 2022 year to date.</p> <p>One internal complaint was reviewed and indicated that this was resolved in a timely manner with documentation to the complainant as per the policy.</p> |

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| | | <p>One resident was supported to make a complaint by a Health and Disability advocate in 2020 with this resolved in a timely manner. A complaint was lodged by the Health and Disability Commission in 2020 and was closed after the complainant withdrew their complaint. A complaint was lodged with the district health board and Health and Disability Commissioner in 2021. This was an anonymous complaint and was closed by the Health and Disability Commissioner with no actions 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>This audit included interviews with five residents (two from the rest home and three at hospital level of care including one young person funded through a disability contract), and three family members (two from the dementia unit and one from the hospital area). 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. Twenty incident forms reviewed identified family were informed where required. Open disclosure is practised and documented when family are contacted. The general practitioner interviewed, reported satisfaction with communication from staff. Family interviewed confirmed that they were kept well informed of changes to visiting and to resident engagement during the Covid-19 lockdown periods.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>Cromwell House and Hospital is certified to provide rest home, dementia level care and hospital (geriatric and medical) for up to 52 residents.</p> <p>Of the 52 beds identified as being certified, five are identified as being rest home beds only with one converted to a lounge for rest home residents. There is a 22-bed secure dementia unit with 18 residents on the day of audit. There are 25 dual purpose beds with 23 residents requiring hospital level of care (including two young people with disability [YPD] and one with long term service-chronic health conditions [LTS-CHC]) and three residents requiring rest home level of care including one LTS-CHC. There were no residents under the primary options acute care (POAC) contract.</p> <p>Cromwell House and Hospital is owner/operated by three directors who maintain regular contact. One of the directors is referred to as the director/chief executive officer and they take responsibility for maintenance. They have a master's degree in technology and is a registered plumber. The director/chief executive officer lives on site and staff are able to ask for assistance if required during the night shift. The manager (director) is a registered nurse and is on site seven days a week. A third director is not actively engaged in the day-to-day operations of Cromwell House and Hospital.</p> <p>The mission statement and philosophy of care are documented and given to any potential or new resident and/or</p> |

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| | | <p>family on admission to the service as part of the welcome pack. The 2021 business plan and goals have been reviewed. Goals for 2022 are documented. The owner/directors liaise with an employment law firm, health and safety advisor and are members of an aged care association with opportunities to attend conferences and provider meetings.</p> <p>The directors have owned a 56-bed rest home and hospital in close proximity to Cromwell House and Hospital and the manager of Cromwell House and Hospital has been a facility manager at the other site over the last three years. The manager attends the Age-Related Care forums and cluster meetings at the district health board when offered. This has been attended via zoom during the lockdown periods.</p> <p>The clinical leader (comprehensive registered nurse) at Cromwell House and Hospital has been in the service for over 23 years and has extensive experience in overall clinical and operational management. They have maintained relevant professional development hours.</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 manager and clinical leader. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidence-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 with evidence of resolution of issues in a timely manner.</p> <p>The schedule of quality/staff and registered nurse meetings allows for discussion and review of data; and meeting minutes confirmed resolution of issues raised. The shortfall identified at the certification audit has been addressed. Staff reported that they are kept informed of quality improvement and risk management through meetings noting that the meetings have been replaced during Covid-19 lockdowns with emails and a staff Facebook page that includes memos, updates, and any clinical information. Resident meetings are held three-monthly to allow for discussion around quality improvement data. The family satisfaction survey is accessed on the internet. There have been seven respondents in 2020 and 2021 with a high level of satisfaction in quality of care, caring staff, responsive management, activities, social atmosphere, and food services. The last resident survey was completed in April 2021 with a high level of satisfaction.</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</p> |

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| | | <p>hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise, and risks are eliminated, minimised, or isolated. Health and safety is audited monthly. Review of incidents, risks, accidents, and clinical issues are discussed through quality/staff meetings as part of the health and safety programme.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | PA Low | <p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported with these signed off by the manager or clinical leader.</p> <p>Twenty incident forms were reviewed, and these showed evidence of investigations with sign off by the manager or clinical leader. Eleven incident forms were reviewed where residents had an unwitnessed fall. Neurological observations were not always completed as per policy. Both family and the general practitioner interviewed confirmed that incidents are reported in a timely manner.</p> <p>The manager could describe the statutory and/or regulatory obligations in relation to essential notification reporting and could describe the process of notification to the correct authority where required. Two section 31 notifications have been sent to HealthCERT for a pressure injury and a resident who absconded.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>There is an established system in place for human resource management. Staff records reviewed (two registered nurses, two HCAs, one cook), included an employment agreement and a position description. Reference checks are completed for new staff. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation with a record of this maintained on staff files reviewed. The orientation programme covers key aspects of the organisation and service delivery including special care requirements for hospital, dementia, and rest home levels of care. Two new care staff were interviewed, and both stated that they had completed a comprehensive orientation with a buddy system operating. There is a schedule for staff annual performance appraisals, and all appraisals have been completed as scheduled.</p> <p>The 2020 training plan is implemented with a high number of care staff attending training sessions. The physiotherapist provides safe manual handling sessions. Staff complete competencies relevant to their role such as fire safety, infection control, restraint, challenging behaviour, and medications.</p> <p>There is a total of 17 HCAs. Three have completed NZQA level one Careerforce; four have completed level two (three currently in training), six have completed level three (four in training), and three have completed level four (four in training). Staff working in the dementia unit have either completed level four or level seven training or are currently training. A review of rosters for the past three months confirmed that there was always an HCA trained in dementia care on duty in the dementia unit.</p> |

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| | | All four registered nurses and the clinical leader and manager are interRAI trained. |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>The process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided. Staff rosters are developed by the clinical leader. The service uses bureau or existing staff to relieve for staff who are on leave. Rosters reviewed confirmed that staff are replaced when on leave.</p> <p>The manager and clinical leader share the on call after hours. Staff stated that on call staff respond promptly. The manager and clinical leader are currently working as rostered registered nurses. Registered nurses work either an 8-hour shift or 12-hour shifts to cover the 24-hour RN on duty.</p> <p>Healthcare assistants (HCAs) are allocated to each area. The dementia unit, with 18 residents, is staffed by two HCAs on both the AM and PM shifts and there is one HCA overnight. The healthcare assistants in the dementia unit also provide care and support for the residents in the five rest home beds that are in the same building as the dementia unit. The three residents with rest home care are directly outside the dementia unit. At night, staff from the hospital area can also support rest home residents. Two rest home level residents interviewed stated that they were well supported. The shortfall related to staffing for rest home residents has been addressed.</p> <p>There are three healthcare assistants rostered onto the AM shift in the hospital building, two HCAs in the afternoon and one HCA overnight. They support 23 residents requiring hospital level of care.</p> <p>The registered nurse on duty in the mornings spends time in the dementia unit each day. The two RNs interviewed also stated that they go into the dementia unit to provide support on PM and night shifts when required and routinely.</p> <p>A diversional therapist is based in the dementia unit. There are cleaning staff employed.</p> <p>The rest home residents are supported by one of the two HCAs rostered onto the morning and afternoon shifts. The resident interviewed who was using rest home level of care stated that they were well supported. At night, they are supported by the caregiver or registered nurse in the hospital. The shortfall related to staffing for rest home residents has been addressed</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and</p> | FA | <p>There are policies and procedures in place for all aspects of medication management, including self-administration. The service utilises roll packs. The service uses an electronic medication management system.</p> <p>All medications were securely and appropriately stored. Registered nurses or senior HCAs, who have passed their competency, administer medications. Medication competencies are updated annually. Medication charts</p> |

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| <p>timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>have photo IDs. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.</p> <p>Ten electronic medication charts and signing charts were reviewed. All medication signing sheets aligned with the medication charts.</p> <p>Electronic medication profiles reviewed were legible, up-to-date, and reviewed at least three-monthly by the GP. All medication charts reviewed have 'as needed' medications prescribed with an individualised indication for use and effectiveness recorded by staff. The medication round was observed, and demonstrated safe administration of medications as prescribed. The medication fridge has temperatures recorded daily and these are within acceptable ranges and room temperature recording was maintained within the safe range. Medication management audits are completed as part of the internal audit system.</p> <p>Standing orders are in use (RNs only) and these have been reviewed annually by the GP. There were no self-medicating residents on the day of audit and no vaccines are stored on site.</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>There is a fully equipped commercial kitchen, which is located on the dementia side of the facility. The service has one lead cook and an assistant cook who cover Monday to Sunday and perform all duties in the kitchen. The majority of food is prepared and cooked on site. All kitchen staff have completed food safety training. The menu has been approved by a dietitian and a food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation, and guidelines.</p> <p>All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily, and these were all within safe limits. All food is served directly from the kitchen to residents utilising a Bain Marie for the dining rooms and a scan box for deliver to resident rooms as required. Food on the day of audit was seen to be served at an appropriate temperature. All food in the freezer and fridge was labelled and dated. The food control plan expires 30 July 2022.</p> <p>All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes, and dislikes. This profile is reviewed six-monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for. Alternative meals can be accommodated if needed. Residents' weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</p> <p>The partial attainment at the previous audit relating to this area has been resolved</p> |
| <p>Standard 1.3.6: Service</p> | <p>FA</p> | <p>Interview with the GP evidenced that care provided is of a high standard and he is kept informed. Family</p> |

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| <p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | | <p>members interviewed stated care and support is good and that they are involved in the care planning.</p> <p>Healthcare assistants and RNs interviewed stated there is adequate equipment provided, including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. There were four wounds being managed (one stage one pressure injury, one diabetic ulcer, one blister and one graze). Wound management and monitoring occurred as planned. All have appropriate wound care management plans documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed. Care plans document allied health input. A sample of wounds reviewed in detail included a link to short- and long-term care plans.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to) weight and vital signs, blood glucose, pain, food, and fluid, turning charts, and neurological observations (link 1.2.4.3).</p> <p>Short-term care plans were in use for changes in health status and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>There is one diversional therapist who works forty hours a week. On the day of audit residents were observed in a sing-along, exercising, and listening to the news of the day.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Rest home residents are invited to join the dementia and hospital programme. Individualised programmes are implemented as per resident choice. Residents have the choice of a variety of activities including exercises, games, newspaper readings, music and walks in the garden. Happy hour is held twice a week. The dementia programme is tailored to the dementia residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are no church services but a Roman Catholic priest visits weekly to give communion. Many residents who are able, go out to church services on a Sunday.</p> <p>There is a van outing twice weekly. Special events like birthdays, Easter, Mothers' Day, Anzac Day, and the Melbourne Cup are celebrated. There is entertainment twice weekly. There is community input from the local schools, dance groups and a Chinese children's' orchestra. Those able, go out shopping and to cafés.</p> <p>There is a Cromwell House cat and the manager's dog comes in on a daily basis.</p> <p>The resident identified as a young person with a disability has individual outings to shops and a nearby park in her wheelchair with the assistance of a staff member. The resident likes shopping, cafés, and movies.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the</p> |

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| | | residents past hobbies and present interests, career, and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed had been evaluated by registered nurses six-monthly, or when changes to care occurred and document progress of achievement towards the desired goal or outcome, this is an improvement from the previous audit. Activity plan evaluations were completed six-monthly. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the care plan reviews and GP visits. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | <p>The building holds a current warrant of fitness which expires 17 November 2022. The director/CEO is a certified plumber and builder and assists with all maintenance. A contracted electrician is available when required.</p> <p>Electrical equipment has been tested and tagged and medical equipment calibrated annually as per schedule and are next due to be checked July 2022. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility.</p> <p>Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. The dementia unit has a fenced off garden.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care to residents in the rest home, hospital, and dementia unit.</p> |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are | FA | In the rest home there is now a combined dining room and lounge. The shortfall relating to this identified at the previous audit has been fully satisfied. |

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| <p>provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</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>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>A monthly log of infections and short-term care plans are completed for all resident infections. Infection control data is collated monthly and reported at the three-monthly infection control meetings and monthly staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices, identifying trends and corrective actions/quality initiatives. Infection control data is on display for staff. The infection control programme is linked with the quality management programme. Benchmarking occurs through an external consultant.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP that advises and provide feedback/information to the service. There have been no outbreaks</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Cromwell House and Hospital has policies and procedures around restraint minimisation and safe practice that have been developed by an aged care consultant and reviewed in line with the policy. Care staff interviewed stated that there is a focus on minimising the use of restraint. There were no residents using restraints or enablers.</p> <p>Staff receive training on restraint minimisation and safe practice and complete competency questionnaires. Staff had received training in 2021 around challenging behaviours.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p> | PA Low | <p>Twenty incident forms were reviewed. All were reviewed and signed off by the clinical leader or manager in a timely manner. Eleven of the twenty incident forms were for residents who had an unwitnessed fall. Five of the eleven unwitnessed falls had neurological observations completed as per policy.</p> <p>Six of the unwitnessed falls did not show evidence of neurological observations completed as per policy. Staff stated that some residents in the dementia unit had behaviours including sitting on the floor, however, they were identified as an unwitnessed fall on the incident reporting system.</p> <p>Staff use closed circuit television to monitor communal areas and there is always someone in the lounge/dining area in the dementia unit when residents are there. Staff stated that they had observed residents fall had not completed the neurological observations. There was no</p> | <p>Six of eleven incident forms did not show that neurological observations were completed as per policy for residents who have an unwitnessed fall.</p> | <p>Ensure that neurological observations are documented for residents who have an unwitnessed fall as per policy.</p> <p>90 days</p> |

| | | | | |
|--|--|---|--|--|
| | | documentation to confirm that the falls were, in fact, witnessed. | | |
|--|--|---|--|--|

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.

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|--------------------|
| No data to display |
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End of the report.