Final Inspection Report

Presbyterian Support Central – Huntleigh Home

Date of inspection: 30 November 2009

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HealthCERT
Quality & Safety
Regulation and Governance
Ministry of Health

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Undertaken	**30 November 2009**
File Ref:	**WPR48**
Provider:	**Presbyterian Support Services, Central**
Contact Person:	**XXX XXX**
Premise:	**Huntleigh Home** **221 Karori Road** **Karori**

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Executive Summary

History

Presbyterian Support Central (PSC) purchased Huntleigh Home in July 2009 and were certified for one year following a provisional audit.

Previous Recent Complaints

There were no complaints known to HealthCERT reported between July and October 2009.

Nature of current complaints

Two complaints were received by HealthCERT in November 2009 one was from a relative whose parents reside at Huntleigh and the other was made anonymously.

Mr XXX, whose parents are residents at Huntleigh, raised concerns around medication administration, unexplained bruising on his mother's arms, poor family notification regarding a change in health status, lack of cleanliness in resident rooms, no apparent policy to support the management of incontinence and resident call bells being inaccessible to residents.

The anonymous complainant alleged staff did not communicate clearly with residents, the management of catheters and wound care appeared inadequate, call bells were not answered, staff training did not appear adequate and there did not appear to be continuity of care between shifts.

In addition to these two complaints, the District Health Board (DHB) had received a concern in relation to care provided to a respite client while at Huntleigh. Although this was not formalised as a complaint the issues raised – groin rash and reduced mobility – were relevant to consider during the inspection.

Further information (DHB/HDC)

Capital and Coast District Health Board (DHB), XXX XXX and XXX XXX, have been meeting monthly with XXX XXX (Manager) and XXX XXX (Regional Manager) regarding progress and improvements at Huntleigh Home. A letter from Capital and Coast DHB, dated 20 October, indicated the monthly meetings would cease as the DHB *"are satisfied with the work completed to date, and scheduled on going, will enable Huntleigh to meets its contractual requirements and achieve positive results in the up coming post purchase surveillance audit."*[1]

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[1] Quote from Capital & Coast DHB letter dated 23 October 2009

Findings

The unannounced inspection was undertaken 30 November and the following allegations raised in the complaint/s were substantiated:

1. Poor family notification regarding a change in health status (1.1.9.1) – of the 16 incident reports reviewed only 6 evidenced family notification following the event.

2. Staff training did not appear adequate (1.2.7.4, 1.2.7.5) – although there was a staff training plan it required updating. In addition a Registered Nurse orientation programme had been developed however had not been completed on the day of the inspection. It is acknowledged a significant amount of training has been provided since PSC purchased Huntleigh.

3. Lack of cleanliness in the rooms (1.4.6.1, 1.4.6.2) – Huntleigh had recently employed a second cleaner Monday through Friday. The cleaning schedules and procedures were not current and overdue for review. An odour was evident throughout the facility and the provider was reportedly replacing the carpet in an attempt to eliminate.

4. Call bells were not answered promptly (1.4.7.5) – call bell response was tested during the inspection with a 4-6 minute response time. Residents interviewed (6 of 7) stated response time was usually anything between 10 and 40 minutes.

5. Service delivery issues such as continence and wound care management (1.3.3.2, 1.3.4.2, 1.3.4.4, 1.3.8.2):

   5.1. Resident/family involvement – of the 7 files reviewed 5 did not evidence resident and/or family involvement in care planning (1.3.3.2).

   5.2. Assessment (continence/wound) – there were an extensive range of assessment tools evident. Review of the files of the three residents involved in the complaints had not had continence assessments undertaken and two did not have nutritional assessments completed in their file/s (1.3.4.2). There was no evidence of assessment outcomes being communicated to residents (1.3.4.4) and in the case of respite clients there was a lack of planning in respect of return to the community (1.3.8.2).

In addition to the issues raised through the complaint/s there were two areas identified during the inspection requiring corrective action:

1. Service delivery is linked to the quality system (1.2.3.5) – although complaints were responded to there was no formal register or evidence of quality loop closure in respect of complaint management.

2. Professional qualifications are validated (1.2.7.2) – on the day of the inspection the annual practising certificate of the Care Manager and General Practitioners were unable to be evidenced.

Two areas for improvement were noted against the following areas:

1. Service provider availability (1.2.8.1) – while there was a document outlining the rationale for staff numbers, the document was not controlled nor available at the facility.

2. Medicine management system (1.3.12.1) - some of the charts required complete rewriting by the General Practitioner as they had reached the end of the medication chart page.

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There were two areas of concern identified during the inspection discussed with the provider at the summation meeting:

1. Reconfiguration of certified services. On the day of the inspection there were 36 hospital level residents – HealthCERT records show 29 hospital level beds - 7 of whom were in the Rest Home wing: HealthCERT had no previous notification of the provider's intent to 'swing' beds.

2. Staff culture. During the inspection there were 2 incidents observed that less than optimal – negative non-verbal cues during a staff/resident interaction (1.1.3.7) and bed to wheel chair transfer that did not demonstrate best practice (1.3.4.2). The provider acknowledged there had been performance issues identified since the purchase which were being managed on an individual basis.

Service Description

Presbyterian Support Central - Huntleigh – provides Aged Residential Care ***Hospital – Geriatric and Rest Home*** services. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	36	29
Rest Home	34	41
Total	**70**[2]	**70**

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by ***Presbyterian Support Central - Huntleigh***, are being provided in compliance with section 9, Health and Disability Services (Safety) Act 2001, that is a person providing health care services of any kind must do so whilst meeting all relevant standards.

Health and Disability service providers are required under section 9 of the Health and Disability Services (Safety) Act 2001 (the Act) to provide services:

(a) 'while certified by the Director-General to provide health care services of that kind; and
(b) While meeting all relevant service standards;
(c) in compliance with any conditions subject to which the person was certified by the Director-General to provide health care services of that kind; and
(d) in compliance with this Act.'

The inspection team

The inspection was undertaken by XXX XXX, Senior Advisor HealthCERT and XXX XXX, Senior Advisor HealthCERT, under the delegated authority of the Director-General of Health.

Methodology

The inspection was conducted to investigate the complaints made to the Ministry of Health, which if substantiated, may have resulted in systems failures and non-compliance against the Health and Disability Services Standards. Findings are according to the Health and Disability Services Standards NZS8134:2008.

[2] HealthCERT has no record of the provider operating a number of 'swing' beds. On the day of the inspection there were 7 hospital level residents residing in the Rest Home wing.

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The inspection was conducted utilising the following methods:

- Interview with Manager
- Interview with Registered Nurse (Bureau)
- Individual staff interviews
- Relative/ Resident interviews
- Observation: During facility tours and casual observation of the facility
- Observation: Residents and Staff
- Document and policy review: See Appendix A for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of residents' notes from the facility was audited.

Limitations

The scope of the inspection was limited to the issues raised in the complaint. During the inspection related issues were also considered.

Entry Meeting

Start 0800 hours, finish 0830 hours.

Attendees:

- XXX XXX (HealthCERT)
- XXX XXX (HealthCERT)
- Mr XXX XXX (Manager, Huntleigh)

The introduction meeting covered the following points:

- A copy of the letter of introduction addressed to Mr XXX XXX was provided to Mr XXX XXX.
- A proposed agenda for the day was discussed including a request to interview any relatives or health professionals visiting the facility during the course of the day.

The inspection commenced with a tour of the facility.

Summary of Inspection findings

Consumer Rights during Service Delivery - Standard 1.1

1.1.3.6 – Fully Attained

Six residents were interviewed during the inspection – two were the parents of Mr XXX. All residents commented on the improvement in care delivery and the quality of the food served since PSC purchased the facility. 1 resident commented on the freedom to have visitors at any time and three commented on being able to individualise their rooms.

Policies were current and included Informed Consent, Resident Rights, and Resuscitation. A record review showed the majority of files had signed consent forms (5 of 7 files).

1.1.3.7 – Fully Attained

Residents interviewed stated they felt safe at Huntleigh and commented on the approachable management team. 4 of the 5 clinical staff interviewed were aware of, and stated they worked within, the Code of Rights.
There was a policy on Abuse & Neglect.

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Staff training records were sighted and included staff attendance at the following sessions: Advocacy Services (9/07/09); Sliding Sheets (9/11/09 – 9 staff), Challenging Behaviour (18/11/09 – 17 staff), Manual Handling (16 & 27/10/09 – 13 staff).

Incident and accidents were recorded, and monthly trending was evidenced.

Note: During the inspection a cognitively aware resident requested assistance while being interviewed. The staff member who responded rolled her eyes and expressed negative non verbal cues, which the resident noted. This response may not be indicative of the whole service however is suggestive of a particular staff culture. This observation was discussed at the closing meeting and senior staff acknowledged issues in relation to the culture that were being addressed through performance monitoring.

1.1.8.1 – Fully Attained

There was an extensive range of assessment tools in resident files which were appropriate and based on good practice. There were a range of policies including Promotion of Urinary Continence, Urinary Infection, Suprapubic Catheter Change, Wound Management, Skin Tears. Staff training records evidenced training had recently been provided in Wound Management (8/06/09) and Continence Management (19/05/09) – these were both areas of concern raised by the complainants. Adequate supplies were observed to implement the policies. The records reviewed evidenced good linkage with specialist staff including Outpatient Department, Mary Potter Hospice, District Nurses.

1.1.9.1 – Partially Attained

There was an Open Disclosure policy that stated family would be notified within 24 hours of an incident. 6 of the 16 incident reports reviewed evidenced family notifications. A review of files evidenced a degree of family communication – 3 of the 7 files were residents involved in the complaints.

Six residents were interviewed during the inspection – 2 were the parents of Mr XXX – 4 residents felt satisfied that their family had good involvement. 1 relative was interviewed and commented there was a lot of interaction with the family.

Corrective Actions:

- The nominated contact is notified of resident incidents within 24 hours of occurrence in line with the policy.

Organisational Management - Standard 1.2

1.2.3.3 – Fully Attained

The policy manual reflected best practice. A staff signing sheet was in place although did not appear complete. An interview with the Quality Manager indicated new policies were put into the 'What's New' folder - staff meeting minutes (October '09) verified this practice. Of the 5 clinical staff interviewed, 3 were clear where to seek information, 2 were not so sure - referring to asking staff as opposed to checking policies. Further exploration identified these staff were aware of their clinical parameters.

1.2.3.5 – Partially Attained

There was a complaints policy. Three complaints were reviewed while on site. All related to service delivery and had been received within a month of each other. There was evidence of follow-up, but no closure of quality loop noted ie. Where a corrective action had been put in place in response to a complaint there was no review of effectiveness. There was no

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complaints register in place. 16 incident forms were reviewed and a number were not fully completed. There were systems in place to aggregate and trend incidents monthly. 1 hospital level resident felt able to raise concerns.

Corrective Actions:

- Develop a complaints register and a system to evidence closure of the quality loop

1.2.7.2 – Partially Attained

Annual Practising Certificates (APC) were reviewed. The Care Manger and General Practitioner/s APC's were not sighted.

Corrective Actions:

- Provide copies of the Care Manager and General Practitioner/s APC's.

1.2.7.4 – Partially Attained

Training records evidenced 17 staff (the majority of whom were Care Giver's) had completed Orientation 1 (work book) between April and July 2009. There was a Registered Nurse (RN) orientation manual recently developed but yet to be implemented. There was no information provided in respect of orientation for agency staff – however the agency RN on duty was familiar with the facility, and stated she had received a 3 hour orientation on her first visit. She also stated she regularly worked at the facility so knows the residents well.

Corrective Actions:

- Implement the Registered Nurse orientation programme, and an orientation schedule for agency staff.

1.2.7.5 – Partially Attained

Training records showed a range of in-service education has been offered since PSC purchased Huntleigh in July 2009 including Advocacy Services, Sliding Sheets, Challenging Behaviour, Manual Handling, Wound Care and Continence Management. There was a training plan evident which was incomplete. 3 of the staff interviewed had completed or nearly completed their ACE training, and 3 staff commented on the training sessions, which had increased since July. They said the topics were relevant and useful. There was a competency test for medication administration in place and a current policy. Training records verified 5 RN/s and 2 Care Givers had completed a competency assessment. 3 staff mentioned they did not do medication administration as they did not have that "qualification".

Corrective Actions:

- Update the training plan.

1.2.8.1 – Fully Attained

Rosters were managed on computer programme: Time Track; a system that allows the Manager internal email communication to single staff, groups or all staff. The Manager stated hours were increased based on acuity (i.e. To manage the hospital level residents living in the Rest Home wing) – this was evidenced in the Staff Meeting minutes (October), and during staff interview. Bureau staff were used to cover gaps, and were also identified on Time Track. The Manager reported two bureaus were used in support of consistency. The bureau RN had an awareness of the facility, residents and local practice. An on-call roster was evident in the Nurses area which was not visible to the public.

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Staff numbers were adequate on the day of the inspection.

- Hospital staff hours: 6 Staff AM; 5 staff PM; 2 staff Nocte
- Rest Home hours: 5 staff AM; 4 staff PM and 1 staff Nocte.
- Cleaning staff: 2 x 6 hours Monday – Friday, 1 x 6 hour weekend.
- Note: not all the staff on the AM and PM shift are full hours. Clinical hours were not reduced in the weekend.

On the day of inspection there was no staff/ skill mix rationale on site – the Regional Manager stated this document was held at head office, and staffing was monitored by QPS. A copy of the document was emailed 2 December – Appendix 2. It was noted the rationale was not document controlled and it was considered appropriate that a copy be held at facility level to support manager decisions in respect of staffing.

Improvement Note: Document Control the staffing rationale and consider a copy being available at each facility.

Continuum of Service Delivery - Standard 1.3

1.3.3.2– Partially Attained

Seven care plans were reviewed during the inspection, 3 were resident named in the complaints. Five of seven care plans reviewed did not evidence resident or family involvement in care planning. There was evidence of family contact in the progress reporting. An interview with the Recreation Officer demonstrated strong links with family during development of the lifestyle plan however this assessment was not integrated into the resident file. 1 hospital resident did not indicate strong family involvement in care planning.

Corrective Actions:

- Ensure there is evidence of resident and/or family involvement in all stages of care planning.

1.3.4.2 – Partially Attained

A range of assessment tools were seen in the 7 files reviewed relating to a wide range of care requirements including: pain, wound management, pressure area care, mobility and hygiene. In two of the three respite/convalescent files reviewed there were incomplete assessments. There were no continence assessment in the 3 resident files named in the complaints, and two did not have nutritional assessments.

Policies were evident and current. Training on a range of topics had occurred including Manual Handling - provided 16 and 27 October.

Note: During the inspection a bed to wheel chair transfer was observed. The transfer was undertaken without verbal cues from the staff member to the resident. The wheelchair brakes were not locked causing the chair to move, and resulted in the resident sitting on only half of the chair. The potential for left leg trauma was high.

Corrective Actions:

- Assessments for all residents are completed according to clinical need. This includes respite and convalescent residents.

Recommendation:

The observation made during the inspection is considered significant, and although it is acknowledged training in respect of manual handling has been undertaken, it is

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recommended a series of 'spot' audits/observations be undertaken where assistance involves a transfer approach.

1.3.4.4 - Partially Attained

In the 7 files reviewed assessment outcomes were not recorded as having been discussed with the resident – this was the case for respite/convalescence and permanent residents. 4 of the residents commented on having had an initial discussion, but there was reportedly no further interaction in respect of care provision.

Corrective Actions:

- Residents are informed of assessment outcomes and planning future care.

1.3.5.2 – Fully Attained

There was comprehensive care planning following completed assessments. Interventions noted in the Care Plan were in an easy to read and clear format for all clinical staff. There was clear use of short term care plans (noted to be on a different colour page) that related to wound care, urinary tract infection treatments and relevant short term care needs. All the clinical staff interviewed knew of short term and long term care plans. There was a handover system in place to alert staff to care changes.

1.3.6.2 – Partially Attained

There was evidence of links with other health professionals as required, for example District Nurses, GPs and specialist outpatient appointments. The lifestyle/recreation plans were held by the Recreation Officer.

Corrective Actions:

- Integrate the recreation plans into the resident files.

1.3.8.2 – Partially Attained

Permanent residents had individualised and completed evaluations. There was a lack of planning and review in the respite/convalescent client files reviewed to support their return to the community. 1 respite client commented on a thorough initial assessment, but further progress had not been discussed with her. 2 of the 5 clinical staff interviewed were not aware of any difference for respite clients' in respect of interventions to maintain independence and enable return to community.

Corrective Actions:

- Evaluate all residents' progress towards their goals. This includes respite and convalescent clients to facilitate independent return to the community.

1.3.12.1 - Fully Attained

The administration of medications in both Hospital and Rest Home evidenced good practice. Medications were individually labelled and there was use of a blister packed system. Medication trolleys were clean and secured when not in use. Fridge storage of nutritional supplements and antibiotics was available in both Rest Home and Hospital and was appropriate to the need. Both fridges were at an appropriate temperature. The medication charts were sighted, and were clear and legible, and reviewed regularly by the GP.
Improvement note: Some of the charts required complete rewriting by the GP as they had reached the end of the medication chart page.

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1.3.12.2 – Fully Attained

Policies and procedures on medication management are clear and current, including the use of self medication. 1 resident self medicated and spoke well of the process.

1.3.12.3 – Fully Attained

Medication competency training was in place and all clinical staff interviewed were aware of the requirements. There was a system for RN competency.

Safe and Appropriate Environment - Standard 1.4

1.4.6.1 – Partially Attained

The cleaning schedule and cleaning procedures were not current. These were written by the previous owners and due for review in 2007. A second cleaner had been employed which effectively doubled the cleaning hours Monday to Friday. There was essentially one cleaner in the Rest Home and Hospital.

Corrective Actions:

- Review cleaning policies and procedures to reflect practice.

1.4.6.2 - Partially Attained

Cleaning practice was not consistent. During the inspection lino floors were observed to be sticky following cleaning and food scraps remained on the dining room floor mid afternoon from lunch. 3 rooms were observed to have dust on shelves and surfaces. There was a stale urine odour throughout the facility. The Manager indicated replacement carpet is on the upgrade schedule. There did not appear to be an audit cleaning schedule.

Corrective Actions:

- Commence a cleaning schedule and audit compliance. Upgrade carpet to eliminate the stale odour that is evident.

1.4.7.5 – Partially Attained

There was an appropriate call bell system throughout the facility. The timeframe for response to call bells when tested during the inspection was 4-6 minutes. 6 out of 7 residents commented that the time for response was anything between 10 – 40 minutes. Call bell response is not audited but the system does have capacity for this feature. During the inspection the call bells were noted to be within reach of the residents.

Corrective Actions:

- Audit call bell accessibility and response time.

Infection Control and Prevention –Standard 3

3.2.2 – Fully attained

The policies and procedures on specimen collection and storage were in keeping with accepted practise. There was a laboratory test form box for Nurse Collection and a separate fridge available and accessible for storage of specimen collection until laboratory pick up. There has been improvement in communicating results with residents and relatives.

Summation meeting

A summation meeting was attended by

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- XXX XXX, Regional Manager
- XXX XXX, Facility Manager
- XXX XXX, Quality Manager

XXX XXX thanked the facility for their participation and approach to the investigation recognising that this was an unannounced inspection. XXX XXX noted that relatives interviewed had been complementary to the service, and that staff were approachable. She confirmed that there would be findings against the Health and Disability Services Standards and these would be likely to include the following areas:

Consumer Rights:
- Full and frank information and open disclosure (1.1.9.1).

Organisational Management:
- Linkages to the quality management system (1.2.3.5)
- Validation of professional qualifications (1.2.7.2)
- Orientation programme for RN's and agency staff (1.2.7.4)
- Update the staff training plan (1.2.7.5).

Continuum of Service Delivery:
- Develop and evidence consumer/ family involvement in care planning (1.3.3.2)
- Complete consumer assessments according to clinical need (1.3.4.2)
- Communicate assessment outcomes and care planning to the consumer (1.3.4.4)
- Integrate the recreation plans into the resident files (1.3.6.2)
- Evaluation of residents progress towards their goals (1.3.8.2)

Safe and Appropriate Environment:
- Review cleaning policies and procedures to reflect practice (1.4.6.1)
- Commence a cleaning schedule and audit compliance (1.4.6.2)
- Audit call bell accessibility and response time (1.4.7.5).

Key issues relevant to the complaint raised at summation, likely to have corrective actions were:
- Poor family notification regarding a changes in health status
- Staff training did not appear adequate
- Lack of cleanliness in the rooms
- Call bells are not answered promptly
- Resident/family involvement in care planning and evaluation.

Issues not relevant to the complaint raised at summation, not likely to have corrective actions, but recommended to be addressed, were:
- Notification to HealthCERT of swing beds (i.e. Hospital level residents being cared for within the Rest Home wing)
- The culture of staff based on the observation highlighted against 1.1.3.7
- Document Control the staffing rationale and consider a copy being available at each facility
- Some of the charts required complete rewriting by the GP as they had reached the end of the medication chart page.

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Conclusion

PSC - Huntleigh will be required to take the above corrective actions to improve compliance against the Health and Disability Services Standards. On-going monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

Additional Conditions

Additional conditions to be placed on the Certification Schedule:

1. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards 1.1.9.1, 1.2.7.2, 1.3.3.2, 1.3.4.2, 1.3.8.2, 1.4.6.1, 1.4.7.5 as identified in the Inspection Report must be submitted to the Director-General by 11 March 2010.

2. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards 1.2.3.5, 1.2.7.4, 1.2.7.5, 1.3.4.4, 1.3.6.2, 1.4.6.2 as identified in the Inspection Report must be submitted to the Director-General by 10 June 2010.

3. HealthCERT may elect to carry out a verification audit in relation to these corrective actions

4. The Director-General may impose any further condition, or vary any condition, where the Director-General thinks it is necessary or desirable to do so in order to help achieve the purposes of the Act.

Summary for Publication

The Ministry of Health carried out an unannounced inspection at Presbyterian Support Central – Huntleigh on 30 November 2009 in response to complaints about the care provided to residents.

The purpose of the unannounced inspection was to determine whether health care services being provided by Presbyterian Support Central – Huntleigh were being provided in compliance with section 9 of the Health and Disability Services (Safety) Act 2001. That is, a person providing health care services of any kind must do so whilst meeting all relevant standards.

There were aspects of the complaints that were substantiated and Presbyterian Support Central – Huntleigh is required to undertaken the following corrective actions to comply with the Health and Disability Services Standards:

Consumer Rights

- The nominated contact is notified of resident incidents within 24 hours of occurrence in line with the policy.

Organisational Management

- Develop a complaints register and a system to evidence closure of the quality loop.
- Provide copies of the Care Manager and General Practitioner/s APC's.
- Implement the Registered Nurse orientation programme, and an orientation schedule for agency staff.
- Update the training plan.

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Continuum of Service Delivery

- Ensure there is evidence of resident and/or family involvement in all stages of care planning.
- Assessments for all residents are completed according to clinical need. This includes respite and convalescent residents.
- Residents are informed of assessment outcomes and planning future care.
- Integrate the recreation plans into the resident files.
- Evaluate all residents' progress towards their goals. This includes respite and convalescent clients to facilitate independent return to the community.

Safe and Appropriate Environment

- Review cleaning policies and procedures to reflect practice.
- Commence a cleaning schedule and audit compliance. Upgrade carpet to eliminate the stale odour that is evident.
- Audit call bell accessibility and response time.

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Appendix 1

Policies requested

- Care Planning
- Cleaning
- Complaints
- Communication between shifts
- Continence Management
- Elder Abuse & Neglect
- Infection Control policies
- Medication
- Open Disclosure
- Staffing and skill mix
- Wound Management

Other Documents

- Annual Practising Certificates
- Cleaning Schedule
- Complaints register
- Handover sheet
- Incident & Accident reports
- Medication competency records
- Rosters
- Staff education records
- Training schedule &/or plan

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Appendix 2

Enliven
Recommended staffing ratio in facilities

Care worker and Nurse

Proposed staffing ratio (hrs/bed/day)		
	Care Workers	Registered Nurse
Rest home	1.8	0.23
Hospital	2.35	0.8
Dementia	2.0	0.23

Notes:

- Support workers for rest homes: ratio 1.8 hours/bed/day - based on the 24/7 roster calculations in 40 beds rest home
- Support workers for hospital: ratio 2.35 hours/bed/day - based on 24/7 roster calculations in 40 beds hospital
- Registered nurse for rest home: ratio 0.23 hours/bed/day - based on 24/7 roster calculations in 40 beds rest home
- Registered nurse for hospital: ratio 0.80 hours/bed/day - based on 24/7 roster calculations in 40 beds hospital
- If the bed numbers are below 40, the ratio is expected to be slightly higher than the recommended one; if the bed numbers are above 40, the ratio is expected to be slightly lower than the recommended one.
- Care Managers are included in RN figures

Other Costs

Other Costs	Hrs/bed/day						
	Administr	Kitchen	Recreation	Laundry	Cleaning	Chaplain	Quality
Proposed budget	0.09	0.27	0.10	0.12	0.18	0.01	0.03

Note:

- The proposed budget (hrs/bed/day) was the average of actual flash report data for all facilities.
- Recreation - 0.10 hrs/bed/day.
- Cleaning - 0.18 hrs/bed/day. Dementia unit is expected slightly higher than 0.18 hrs/bed/day. Cleaning hours are subtracted from Careworker hours if cleaners are employed specifically

XXX XXX
General Manager

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