

Lifecare Cambridge Limited - Lifecare Cambridge

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Lifecare Cambridge Limited
Premises audited:	Lifecare Cambridge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 July 2016 End date: 12 July 2016
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:	49

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lifecare Cambridge Ltd is continuing to provide rest home and hospital level care to a maximum of 57 residents. Apart from ongoing improvements to the interior and exterior of the building, the manager stated there have been no changes to the scope and size of the services provided.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, interviews with residents, family, management and staff. Two general practitioners were interviewed by telephone; both expressed satisfaction with the care and services being provided.

There were nine areas identified that require improvement. Six of these were ongoing from the previous surveillance audit in 2015 and relate to quality and risk management systems and the analysis of adverse events. There is still no clear, systematic, planned or coordinated approach to quality and risk. The quality plan has not been updated and limited evidence of monitoring and measuring the quality of service delivery. Although reported incidents were being collated monthly into various categories, there was insufficient evidence this was being fully analysed.

The audit team ascertained that there was no imminent risk to resident welfare or safety and maintained the overall risk rating as moderate, but reduced the timeframe for implementation of corrective actions to 60 days. Three new areas for improvement relate to the management of consumer information, ongoing education for the infection control officer and accuracy of the system for evaluating infections.

The outcome of the audit was notified to the portfolio manager who manages the aged residential contract for the district health board and a director of the company.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families and residents interviewed expressed satisfaction with the caring manner and respect that staff show towards each resident.

There were no residents whom identify as Maori residing at the service at the time of audit. There are no known barriers to residents accessing the service. Services are planned to respect the culture, values and beliefs of all the residents as individuals and as a collective.

Written consents are obtained from the residents' families/whanau, enduring power of attorney (EPOA) or appointed guardians, when necessary.

Residents are encouraged and supported to maintain strong community and family links.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaints register and the information is recorded to meet the requirements of the Code. There were no outstanding complaints at the time of audit.

The documented complaint management system is congruent with Right 10 of the Health and Disability Consumer Code of Rights. A small number of complaints have been received and resolved since the previous audit and the manager has not been notified of

any complaints received by the Office of the Health and Disability Commission. Residents and families interviewed during the audit were aware of how to raise concerns and complaints.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Governance is provided by a group of directors, one of whom is updated weekly by the manager. Policies are being reviewed regularly as our some aspects of service delivery.

Practices for the management of adverse events were known and implemented by all levels of staff. Staff were being managed according to human resources management policy. New staff are recruited in ways that tests their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff. Ongoing staff education is planned and co-ordinated to ensure that staff receive relevant and timely training on subjects related to older people. Training occurs at least monthly through in-service education sessions and presentations by external experts. Staff competency assessments and performance appraisals were occurring regularly.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week to meet the needs of residents who were assessed as requiring either hospital or rest home level care. Registered nurses (RNs) are on site 24 hours a day seven days a week.

The service provider is managing consumer information with the exception of one area that requires an improvement.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident, family and existing community supports and health care professionals, a care plan specific to the resident. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan, as needed. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All but six residents have completed interRAI assessments due to being admitted privately, however, individualised written assessments, care plans and evaluations within required timeframes were evidenced.

Residents are reviewed by their GP on admission and assessed thereafter either monthly or three monthly by their GP depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

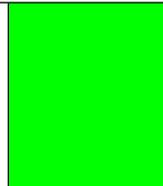
Activity coordinators provide planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a four week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

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.

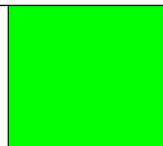
Residents are being provided with safe, age appropriate facilities that are appropriately furnished. There are sufficient toilet, shower and hand washing facilities. All bedrooms are spacious and furnished to meet the residents' needs and likes. Residents can access safe outdoor areas. There is a reactive maintenance process and a long term maintenance programme in place.

Safe and hygienic cleaning and laundry services are provided for residents and the facility is clean. All chemicals were stored securely.

All residents' areas are well lit and ventilated with at least one opening window. The home has effective heating throughout.

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.

Lifecare has established and well known processes in place for determining safe and appropriate restraint and enabler use. On the days of audit the restraint register listed seven residents assessed and approved for bed rails to be in place when in bed for safety reasons. There is evidence that the way the service carries out assessment for restraint use, obtains consent and approval, monitors restraint interventions and conducts regular evaluation and review processes, meets all the requirements of the Restraint Minimisation and Safe Practice Standards

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents and their families. The infection surveillance results for each month are reported and discussed at staff and resident meetings. However the infection control nurse has not completed formal infection control education to maintain their knowledge of current practice and infection data is not being collated accurately and there is no comparison of data to determine trends.

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	45	0	3	2	0	0
Criteria	0	92	0	3	6	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>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the main corridor wall in full view for residents, caregivers and visitors and also presented on the inside of residents’ bedroom doors.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents’ files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advance directives are signed by the resident if competent. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and</p>

information they need to make informed choices and give informed consent.		families/whanau were actively encouraged to be involved in their relative's care and decision making.
<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>	FA	<p>All residents receiving care within the facility have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate through the district health board.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as visiting the local shopping centre or community and school groups regularly visiting the facility.</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>Review of the complaints register and interview with staff and management confirmed a responsive and transparent complaints/concerns management process. The complaints register contains information about the four complaints received since the previous audit. Three of these are related to staff about staff. The documents show that each matter was investigated and managed to achieve resolution with all parties. There was evidence of ongoing communication with all people involved and external advocacy being offered. Residents and family members interviewed confirmed knowledge of the ways to lodge a complaint</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is evidenced in the admissions agreement.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. The Code of Rights and process was also regularly discussed at family/resident meetings. Family/whanau and residents expressed that they were happy with the care at the facility and provided by the</p>

		staff.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The families/whanau interviewed reported that the staff are meeting the needs of their relatives.</p> <p>The families/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>No concerns in relation to residents' abuse or neglect were mentioned. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The registered nurse and clinical manager reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents. The caregivers interviewed demonstrated good understanding of practices that identified the needs of Maori residents and importance of whanau and their Maori culture.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutritional requirements. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they recently attended training in professional conduct and are aware of the importance of maintaining professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice was observed and evidenced in interviews with the clinical manager, registered nurses, caregivers and care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GPs, links with the mental health services, the hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all residents spoke English.</p> <p>The family/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidence adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover.</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>Review of the 2016 annual Business Plan, and interview with one director and the manager confirmed the ways in which directors are involved in the planning and coordination of services. The business plan contains a mission statement, vision, core values and annual goals. The directors visit on site every three months and the manager has almost daily contact with the principal director by telephone and email to discuss progress against goals.</p> <p>The manager who has a nursing background has been in the role for eight years and stated they were attending DHB forums and annual conferences to maintain knowledge and skills required to manage an aged care facility.</p> <p>On the days of audit there were 14 hospital level care residents and 35 rest home residents. The facility accepts people for short term respite care when required. There were no people under the age of 65 years.</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>Documents state that the registered nurse/clinical coordinator is the delegated acting manager during the general manager's absence, with support from the other RNs and senior staff and the directors. The manager and clinical coordinator confirmed that this arrangement has been satisfactory.</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>PA Moderate</p>	<p>Review of the risk plan show that all actual and potential risks are identified. The manager, clinical coordinator and senior staff state they are monitoring the day to day quality of care and where it is obvious that improvements need to be made, actions are initiated and risks are mitigated, but this is not being documented. Visual inspection reveals improvements in the environment, care records review and staff interviews show improvements in the care planning and overall care of residents and in the management of staff since 2015, but there is a lack of documentation about why and how these improvements came about. There is still no systematic approach to quality and risk. The methods that are in place, such as collating of incident reports, is not coordinated or linked to service outcomes. This has been an ongoing concern and the corrective actions related to quality and risk from the previous audit in 2015 have not been fully addressed. There is no evidence that resident safety or other service delivery areas are at risk, therefore the risk rating remains as moderate but the timeframe for corrective action has been reduced to 60 days.</p> <p>Policies are being reviewed yearly by the manager, the reasons for amendments are documented.</p> <p>Risks to individual residents, staff and the organisation are managed through regular clinical risk assessments, monthly environmental hazard inspections and close monitoring of staff who are identified as being at risk. This was confirmed by discussion with the health and safety coordinator and the clinical coordinator.</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</p>	<p>PA Moderate</p>	<p>Review of event records for 2015-2016 show that sufficient detail about each incident is recorded. The event forms record where GPs or family have been notified. The manager is now collating the number and type of incidents each month, where and when these occur. The monthly report includes a general narrative but there is no comparison of month by month data, and the narrative fails to identify trends, risk areas or where action is required. Staff interviews revealed these are being discussed at RN, HCA and health and safety meetings, but this is not adequately recorded in meeting minutes.</p> <p>Interview and records reviewed showed that the manager is aware of the instances that require notification</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>reporting. There have been two instances in the past two years, where issues related to RNs have been passed on to the New Zealand Nursing Council.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Eight personnel records were reviewed, including records of newly appointed staff, staff on different shifts and with different roles, contained evidence of formal appointment via interview, referee and police checks. Each file had the person's experience and records of educational achievement. A new RN and a new healthcare assistant confirmed they had engaged in an orientation programme specific to their role which included competency assessments and being buddied for a variety of shift before commencing duties. The records showed that each RN is maintaining current first aid certificates and has a current practising certificate. Records are kept of the General Practitioner's membership with the NZ Medical Council, the dispensing pharmacist's practising certificate and the physiotherapist's practising certificate.</p> <p>Individual training records for each staff member show attendance at mandatory and other in-service education which is related to the care of older people. A RN is delegated as the training coordinator and sets a yearly staff training calendar. This includes a range of relevant teaching subjects being delivered monthly by the RNs or external presenters. Due to staff changes there is only one RN who has completed training in interRAI. Contingencies for updating interRAI assessments and plans have been put in place with an external consultant until the two recently recruited RNs are trained and competent to complete these. The manager confirmed attendance at conferences and local forums for updates related to the role. There is a requirement in standard 3.4.1 for the infection prevention and control coordinator to attend regular education as required in the provider's agreement with the DHB (the ARC contract). Staff performance appraisals are occurring as required in ARC D17.7.</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 service provider has a documented staffing rationale which determines the ratio of staff to residents according to resident acuity level (for example, a ratio of four HCAs and one RN when there are more than 16 hospital level care residents). On the day of audit there are fourteen hospital level care residents, and two HCAs rostered for each shift. There were two HCAs in the rest home for the morning and afternoon shift. There are seven RNs employed. Rosters reviewed showed two RNs are on site for morning and afternoon shifts and one at night. Another RN is available on call 24 hours a day seven days a week to meet the contractual requirements. There were two HCAs and a RN rostered on for night shift. The staff interviewed stated that sufficient numbers of staff are allocated to meet the needs of residents. Interviews with staff and observations reveal there were enough hours allocated for cleaning and laundry and activities. Staffing meets the contractual requirements.</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>PA Low</p>	<p>Clinical notes were current and integrated with GP and auxiliary staff notes. On the day of admission full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's admission record reviewed. The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted, however not all residents documents were identified with unique identifiers. No personal or private resident information was observed to be on public display during the days of audit. Archived records were being safely held on site for ten years.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The resident admission agreement is based on the Aged Care Association agreement. The residents' records reviewed have signed admission agreements by the resident/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet. Staff contact the facility manager or nurse manager if enquiries are made by potential perspective residents and/or their family members and if outside working hours an appointment is made.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.</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</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit no residents were self-administering medications.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in locked medicine trolleys in the treatment room. A locked safe is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in a separate fridge with recorded temperatures</p>

<p>guidelines.</p>		<p>documented.</p> <p>The 14 medicine charts sighted have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.</p> <p>The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management.</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>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a four week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner. All main meals are supported by morning and afternoon tea which includes home baking. There is a water cooler situated in the rest home facility where residents/family can obtain cold water.</p> <p>All meals are cooked and plated in the kitchen and then trolleyed to the two separate dining rooms. Residents have the option of trays in their rooms. All residents have their breakfast in their bedrooms and are otherwise encouraged to have their lunch and evening meals in the dining rooms to encourage appetites and socialisation.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the</p>	<p>FA</p>	<p>The nurse manager and registered nurse interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident,</p>

<p>service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The service has implemented for all non-private paying residents the electronic interRAI assessments, with specific assessment tools for residents remaining paper based. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and includes falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>All residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure ulcer risk assessments.</p> <p>The family/whanau interviewed reported their relative receives 'above and beyond the care required' to meet their relative's needs.</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>FA</p>	<p>The seven residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the residents' files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The health care assistants interviewed demonstrated knowledge about the individual resident's they care for.</p> <p>The residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the nurse manager, registered nurse, care and activity staff and medical and allied health services. The registered nurse and healthcare assistants interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</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>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the days of the audit, the registered nurse and healthcare assistants demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</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>The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and preference of the choices of the residents.</p> <p>The facility has one activity co-ordinator who works Monday – Friday, a total of 35 hours per week. The weekly activities plan/calendar sighted is developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The activity coordinator advertises the upcoming activities on the calendar by providing this to residents on the notice boards through the facility. Regular activities include daily newspaper reading and exercises, church services, 'happy hour', regular visiting entertainment. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The health care assistants interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff promote social interaction by inviting and encouraging all residents to join in activities together in the main lounge.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus also throughout the facility.</p> <p>All residents and families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or are not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The health care assistants interviewed demonstrated good knowledge of short term care plans and reported that they are discussed at handover.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</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>	<p>FA</p>	<p>There are eight GPs (from three medical centres) who visits the residents at the facility which also includes an after-hours phone service. The RN in discussion with the GP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GPs interviewed reported that appropriate referrals to other health and disability services are well managed from the facility.</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</p>	<p>FA</p>	<p>The safe and appropriate storage and disposal of waste, infectious or hazardous substances is described in policy, as is storage and use of chemicals. The care and domestic staff interviewed demonstrated awareness of safety issues around managing waste and hazardous substances. Used continence products are disposed of appropriately. The service recycles and minimises waste as much as possible. Observations on site and review of reports from the local governing body confirmed that management of waste complies with legislation and local government requirements. Staff were observed on the days of audit to be using the readily available personal protective equipment. The provider meets the requirements of the aged residential care contract.</p>

substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There has been significant upgrading to the interior and exterior of the facility. This includes the completion of a refurbishment in one wing of the rest home. This has been added to the evacuation plan. The hospital and main corridors have new flooring, fireproofing of walls, upgrades to individual bedrooms and ablution areas, purchase of 20 hi-low electronic beds for the hospital wing, purchase of safe and easy to move chairs, a new dining room in the rest home, external ramps and new gardens. The building and chattels are in good repair and fit for purpose for the people who reside in the home.</p> <p>Electrical testing and tagging is completed by a certified electrician annually; records show this was completed in January 2016. All fire safety equipment is checked monthly by an external service agency, this occurred on day two of the audit. Calibrations of scales and medical equipment and checking of hoists occurs annually. The tags on equipment and documentation in maintenance logs show maintenance occurred in April and June 2016. There is a current building warrant of fitness which expires 17 June 2017. The health and safety officer and maintenance person interviewed and documents reviewed, confirmed that environmental inspections occur monthly and maintenance requests are attended to as soon as possible.</p> <p>There is evidence that hazards are reported and the sighted hazard register is current and updated regularly. Visual inspection revealed that external areas are safe and meet the needs of the resident group. Seating is safe and suitable for older people and there is sufficient shade.</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>The temperature of the water outlet in every resident room is tested monthly, as was confirmed by interview with maintenance staff and review of documents. Records show that hot water temperatures in resident areas do not exceed 45 degrees. Of the 49 bedrooms 22 have ensuite shower and toilet, 18 have hand basins and nine of the rest home bedrooms do not. There are a sufficient number of communal bathrooms for those residents who do not have their own shower and toilet. A shower table is in use for the hospital residents who cannot mobilise.</p>
Standard 1.4.4: Personal	FA	There are various configurations for bedrooms. There are single occupants in each of the rest home bedrooms

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>but the manager stated that double occupancy would be considered and some rooms could accommodate this. The hospital wing has two rooms designated male and female with three beds, one was unoccupied. Four of the hospital rooms have two beds and six rooms are for single occupants. All the viewed bedrooms were spacious and uncluttered. Residents with mobility aids were observed to be moving around the home and in their bedrooms with ease. The residents interviewed expressed satisfaction with their rooms and the spaces they are provided.</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>Hospital and rest home areas are separated into two distinct locations. The hospital area has a large lounge where the majority of residents are supported by staff to eat at meal times. Those who can manage their own meals are provided with lap tables. Movies, ball games and musical entertainment is provided in this room. Visitors are offered the option to visit with the resident in their bedroom and some were observed to be visiting in the large lounge. There are smaller seating areas located throughout the home. A new rest home dining area has been created which is totally separate from the activities room and is within easy walking distance from resident's bedrooms. Residents and family members interviewed expressed satisfaction with the layout of the facility and communal areas. Rest home resident were observed to be accessing the external walking areas and enjoying the gardens.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry services are provided to a high standard. Interview with the domestic supervisor who has been in the role for 15 years and other cleaning and laundry staff confirmed that staff follow documented processes and that there are systems for monitoring the effectiveness of cleaning and laundry. Records show the chemical supplier undertakes monthly checks of the washing machine, titration and Ph level tests of chemicals in use, and ensure that chemical safety sheets are up to date and in place. Staff conduct environmental audits every few months of random areas throughout the home, checks that personal protective equipment is being used and the laundry person seeks resident satisfaction at least annually. The domestic supervisor oversees 10 staff and ensures they have been orientated to their role, attend ongoing education in safe chemical handling, food safety and work cooperatively with dieticians for nutrition. The supervisor engages in performance appraisals with these staff every year.</p> <p>The only change in cleaning and laundry services has been contracting a new chemical supplier in a bid to improve the effectiveness of cleaning products.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	FA	<p>Documented systems are in place for essential, emergency and security services. Exit doors and windows are checked at dusk. Security incidents are reported and staff interviews showed that security matters have been managed.</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>Records sighted show that trial fire evacuations are occurring six monthly, most recently in July 2016. Fire suppression systems are checked monthly by an external service. Staff interviews and review of personnel files provides evidence of current training in emergency preparedness. There is at least one registered nurse on site and another on call twenty-four hours a day, seven days a week. All the RNs and some care staff hold current first aid certificates. Emergency equipment is accessible, stored correctly, not expired, and is stocked to a level appropriate to the service setting.</p> <p>The facility has emergency lighting, stored torches, gas hobs and BBQ for cooking, extra food supplies, emergency water supply, blankets, and cell phones for use during power outages.</p> <p>Call bells are accessible/within easy reach, and are available in all resident areas (eg, bedrooms, ablution areas, ensuite toilet/showers). Staff conduct regular checks of these. Residents interviewed said staff respond to call bells in a timely manner.</p> <p>Emergency and security systems meet the requirements of this standard and the aged residential care contract.</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>	<p>FA</p>	<p>All bedrooms and communal areas have good natural light, safe ventilation, and effective heating. Each bedroom has heaters which can be individually controlled. Residents and family members interviewed stated the home is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>	<p>FA</p>	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The nurse manager is the infection control coordinator and is responsibility for following the programme as defined in the infection control manual, however has not completed formal infection control education (Refer criterion 3.4.1). Infections are monitored by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meetings. If there is an infectious outbreak this is reported to staff, management and where required to the DHB and public health departments. Infection data is not being collated accurately each month and there is no comparison of data to determine trends. (Refer criterion 3.5.1)</p>

scope of the service.		<p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, staff communication book, one to one, shift handover and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</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>The nurse manager/registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at staff and resident meetings. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and GP. The registered nurse and health care assistants interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</p>
<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</p>	FA	<p>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas including managing sharps, managing multi-drug resistant organisms, exposure of blood and body fluids, personal protective equipment, single use items, outbreak management, cleaning disinfecting and sterilisation, waste management, construction and renovations. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>

implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	PA Low	The registered nurse and health care assistants interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the quality assurance manager. Infection control in-service education sessions are held and resident education is provided, as and when appropriate. However, the infection control nurse has not completed formal infection control education to maintain their knowledge of current practice.
<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>	PA Low	All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report, however infection data is not being collated accurately. The monthly analysis of the infections also does not include comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. The service monitors urinary tract infections, acute wound infections and other systemic infections, skin infections, eye infections, respiratory illness (upper and lower) chronic special infections. Antibiotic use is also monitored and evidenced as discussed with the GP. Short term care plans are developed and this information is fed back and discussed with staff and where appropriate resident meetings.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The policy complies with the requirements of the standard. Seven residents have bed rails in place for safety reasons. There were no enablers in use. Review of the restraint register and residents' records and staff interviews show there is understanding of the requirements around use of restraint. Staff knowledge about restraint minimisation is tested by the completion of questionnaires at least bi-annually. Information on the provider's philosophy of restraint minimisation occurs at orientation and ongoing education is mandatory for all staff to attend annually. This was sighted in the annual education plan and in individual staff education records.
Standard 2.2.1: Restraint	FA	Policy clearly describes the processes and agreements required for approval. Responsibility for restraint coordination is delegated to the restraint coordinator who is a registered nurse. The coordinator's role is

<p>approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>documented. Documents sighted and staff interviews show that approval for restraint is always based on the initial assessment for restraint use. The decision to seek approval is made by the restraint coordinator with input from the clinical coordinator, the resident's GP, the resident and/or their family. The restraint coordinator with input from the clinical coordinator and manager determine the need for staff education, the need for family discussion, and the indications for use of various forms of restraint, and any monitoring, observation and evaluation requirements. Approval for ongoing restraint needs is reviewed every six months.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>All residents are assessed on admission and at regular intervals to ensure the parameters around restraint use are clearly identified. Residents' records reviewed showed that alternatives to restraint interventions are considered, the circumstances that indicate restraint use are appropriate and the safety of the resident is taken into account. All the assessments reviewed had been undertaken by the restraint coordinator with input from other RNs and carers. The assessment includes identification details of the resident, the potential effects of restraint use on the resident and their family/whanau, the risks associated with the use of the particular form of restraint and the management and evaluation of those risks, any events in the resident's life that may have an influence on their care or behaviour (eg, trauma or abuse), general needs of the resident, and specific cultural needs (where applicable) and how these would be best met.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Approved restraint is used as a last resort, as stated in policy. The restraint assessment form includes investigating alternative strategies, such as de-escalation strategies or placing the resident in a bed that lowers towards the floor, before implementing restraint. The restraint register and review of monitoring forms shows that the frequency and extent of monitoring is determined on an individual basis. On the days of audit, the seven residents with bedrails in place were being monitored two to three hourly. Documentation of restraint use is held in the residents' files. Monitoring forms, completed by caregivers, are held in a separate location, readily accessible to caregivers. These include details about changing position in bed, toileting and other cares provided. There was evidence of bedrails being removed when new risks associated with their use were identified, and in one instance recently the need to use a bedrail for the resident's safety was agreed overnight with input from the RN on call. (The restraint coordinator works night shift)</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Evaluation and review of the restraint in use for each resident takes place six-monthly. This was seen in the restraint register and in residents' files where restraint is being used. This review assesses the following: alternative strategies explored; desired outcome and whether it is being achieved; the duration of restraint; and the impact of restraint on the resident, staff and family.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The annual quality review of restraint occurred in June. Records sighted and staff interviews showed that this included a review of policies and procedures, a summary of the extent and types of restraint in use, the ways that restraint is actively minimised, checking adherence to monitoring and review protocols and consideration of the restraint education programme.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	<p>PA</p> <p>Moderate</p>	<p>Review of documents and staff and management interview reveal there is no clear, systematic or coordinated approach to monitoring and measuring the quality of clinical service delivery or overall organisational performance, except in the domestic service where surveys and spot checks monitor the effectiveness of cleaning and laundry. The quality policy and the quality plan do not describe systems for quality assurance and how this is monitored and measured. For example, the quality plan lacks measureable goals, there are no documented quality indicators and subsequently no methods for measuring achievement of these. There is no designated quality coordinator or committee who oversee quality and risk activities.</p>	<p>The service provider has still not understood or implemented a robust quality and risk management system.</p>	<p>Develop and implement a quality and risk management system which effectively monitors and measures service outcomes and ensure all staff understand this.</p>

				60 days
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	<p>PA Moderate</p>	<p>Interview with the general manager, health and safety officer, clinical coordinator, domestic supervisor, two RNs and health care assistants (HCAs) and review of documents reveal that the only aspects of service delivery currently utilising a quality assurance approach are domestic services who conduct and report the results of regular audits and surveys. Incident reports are being collated and a simple analysis and narrative report is documented by the general manager each month. The monthly statistics are presented at health and safety, RN and HCA meetings, but the minutes do not reflect any discussion about these. Staff say these are not discussed in terms of trends or preventative actions at the meetings, although actions do occur. Relative and resident surveys are being conducted but there is no evidence that feedback is being further investigated and used to identify where service improvements are required.</p>	<p>There is no clearly described or implemented quality management system. Apart from the audits and surveys conducted by domestic services there is no regular and transparent monitoring of service delivery or stated measurements for assessing the quality of services.</p>	<p>Document and implement a quality management system which reliably measures and monitors service delivery to identify where improvements are required.</p> <p>60 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>Review of meeting minutes, incident and infection control reports and staff interviewed show that the number of events, when and where these occur are being tracked, collated and reported, but there is minimal analysis and no evaluation. The general manager conducts annual surveys of relatives and residents but there is no documented evidence that negative feedback is investigated or that actions occur as a result.</p>	<p>Quality improvement data is not identified in the quality policy or plan. Information is being gathered (for example collation of event reports) but this is not being rigorously or systematically analysed to determine trends and identify where and what improvements are required. Staff attest to actions being taken but this is not recorded nor is there any evaluation to show that actions have</p>	<p>Describe what is considered to be quality improvement data, gather relevant information for analysis to determine cause and effect, initiate remedial actions where required and evaluate the effectiveness of any actions</p>

			resulted in remedying the problems.	taken. 60 days
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>PA Moderate</p>	<p>Review of the current quality plan and policy and interview with the general manager, revealed minimal change to the previous documentation and systems. The quality plan is dated 2015-2016 but the contents are the same as previous years. The quality plan and policy do not contain current or well defined quality objectives and there are no methods for monitoring progress.</p>	<p>There are no clearly described quality objectives or indicators and no implemented processes for measuring achievement against the quality and risk plan.</p>	<p>Develop quality objectives that are measurable and implement systems for monitoring and testing these...</p> <p>60 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>Review of incident reports, meeting minutes and staff and management interviews failed to evidence the ways in which corrective actions are determined, who has responsibility for enacting these, timeframes for carrying them out or how the success of the actions will be measured. There were no obvious methods for evaluating that corrective actions are effective. The majority of incident reports for 2015-2016 do not document corrective actions. There is no evidence in meeting minutes and the general manager could not describe a planned and coordinated approach to determining remedial actions.</p>	<p>There is a lack of planning and coordination in determining the most effective corrective actions, ensuring actions are implemented and evaluating whether or not the actions have had the desired effect.</p>	<p>Ensure that where improvements are required, the actions required to remedy these are documented, that the actions are monitored to ensure these occur and that the effectiveness of the actions is evaluated</p>

				to check that the issues are resolved. 60 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>	<p>PA Moderate</p>	<p>The sighted 2015-2016 incident reports contain sufficient detail about the event, time and place, impact and what happened immediately afterward. The majority of incident reports do not contain descriptions of corrective actions needed to prevent recurrence. Interview of the manager and documents reviewed demonstrate that event information is collated into graphs which display monthly totals of falls (witnessed/unwitnessed) skin tears, medicine errors, resident aggression, and staff injury, where the event happened and what time. There is no tracking by resident. The narrative report attached to each month lacks evidence of any in depth analysis or review of the information. There is no comparison of events month by month or trending to show increase or decrease in the type of event and no stated intentions related to the data. The overall number of incidents is reported at staff meetings; staff stated these are discussed but not in any reflective or analytical way and where there are decisions to take actions, these are not recorded. Subsequently there is no written evidence that remedial actions have occurred or that the effects of these are discussed and recorded.</p>	<p>There is no evidence that incidents are used as opportunities for improvement or to identify and manage risk. The incident data is not adequately analysed or compared to identify areas of risk, where improvements are needed or if improvements or negative trends have occurred.</p>	<p>Demonstrate who incident and accident data is used to make service improvements and identify and manage risk. 60 days</p>
<p>Criterion 1.2.9.1</p> <p>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and</p>	<p>PA Low</p>	<p>On the day of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's admission record reviewed, however all seven files viewed did not have unique identifiers evidenced on progress notes, short term care plans nor 'snapshot' activity forms.</p>	<p>The sample of files reviewed did not contain unique identifiers on progress notes, short term care plans, consents and all snapshot activity forms.</p>	<p>Ensure that all documents related to residents contain uniquely identifying information (for example, NHI and full name or date</p>

setting.				of birth. 180 days
Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.	PA Low	Infection control in-service education sessions are held for staff and facilitated by external resources and staff at the time of audit were able to demonstrate good infection prevention and control techniques. However, the infection control nurse has not completed any formal infection control training.	The infection control nurse has not completed formal infection control education to maintain their knowledge of current practice.	The infection control nurse complete infection control education. 180 days
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Low	A monthly collation of residents with infections is recorded, however data is not being collected accurately. Several residents from June 2015 through to June of 2016 were recorded twice in a month with the same infection. Several residents with an infection in one month were recorded as a new resident with a new infection in the following month though it was the same infection. Several residents with a change of antibiotics for the one infection were re-entered and added again as a new resident. At staff meetings individual residents with infections are discussed to help reduce and minimise risk, however there is no monthly comparison of data to highlight trends.	Infection data is not being collected accurately and there is no comparison of data to determine trends.	Develop and implement a systematic method for accurately collecting and comparing infection information. 180 days

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.