

Lifecare Cambridge Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: 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: 29 May 2015 End date: 29 May 2014

Proposed changes to current services (if any): The service has added a 12 bed extension to the service, which was occupied at the time of audit, these rooms are planned to be dual purpose beds which would be used for rest home or hospital level of care. The service is also in the process of converting three of the current rest home rooms into four rest home rooms. The capacity of the service will increase from 47 to 57 (as the service will convert some of the existing rooms with three bed capacities to two bed capacities).

Total beds occupied across all premises included in the audit on the first day of the audit: 38

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
	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
	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

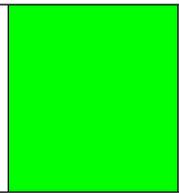
Lifecare Cambridge provides rest home and hospital care services for up to 47 residents. On the day of audit there were 38 residents.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit was conducted to obtain an overview of key aspects of service delivery and to verify ongoing maintenance of the quality and risk management systems. This audit also included a partial provisional audit for a new 12 bed extension to the service. The audit process included the review of policies and procedures, the review of staff files, observations and interviews with residents, family/whanau, management and staff.

The previous certification audit identified six areas of improvement in the consumer rights, organisational management, continuum of service delivery and infection prevention and management standards. Five of these areas show that appropriate actions have been implemented and are now closed. There is one area still requiring further improvements to ensure the infection control programme is documented and reviewed.

There are 16 new areas for improvement identified at this audit. These include seven areas for improvement in the quality and risk and adverse event management systems, five related to ensuring a safe and appropriate environment for the new extension, two in relation to care planning for residents, and two in relation to medicine management. There is one area that is rated as a high risk related to the partial provisional audit, to ensure there is fire evacuation training for the new wing of the service that is already occupied by residents.

Consumer rights

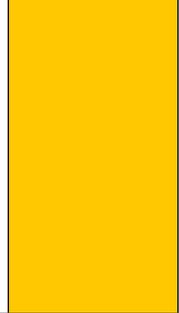
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The previous area for improvement to ensure the admission agreement includes any additional costs that the resident may incur has been addressed. The admission agreement meets the requirements of the DHB.

Residents and staff confirmed there is effective communication. The service has an open disclosure policy. Residents and their families are informed about adverse events that impact them.

The complaints register lists complaints received since the previous audit. Information related to complaint investigations, communication with the parties and resolution of complaints matters is documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The documented 2015 business plan does not contain business goals. There is no evidence that the business plan is reviewed or reported against regularly. It is not clear how much input the owners have in service delivery or the day to day operations of the business. These require attention

The quality and risk standard is not met with several areas requiring improvement. The quality documents in place do not describe a quality management system. There is no clear or coordinated system for reliably monitoring the effectiveness and quality of service delivery. The quality improvement data which is being collected is not being analysed, evaluated or used as a basis for service improvements.

Adverse events are reported; however, there is no evidence that events are investigated or evaluated to prevent recurrence. Incident data is collated but not analysed or discussed with staff.

Staff are recruited according to known and accepted employment practices. New staff are provided with service information and support to safely carry out their duties before commencing work unsupervised. Staff training in subjects related to the care of older people is being provided. There is now evidence that annual performance appraisals are occurring.

There are adequate numbers of staff allocated 24 hours a day seven days a week to meet the needs of the residents currently residing in the facility. Strategies for increasing staff numbers and/or work hours to meet the demands from an additional 10 residents are in place.

Continuum of service delivery

<p>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.</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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There are hand overs each shift to provide information to oncoming staff to promote continuity in care. The service has commenced the implementation of an electronic assessment tool. The care plan documents the care that the resident requires, although there is an improvement required to ensure all the interventions are clearly documented. Where progress was different from expected, the service responded by initiating the use of short term care plans, addressing a previous areas for improvement. The care plans reviewed were evaluated at least six monthly. There is a new area requiring improvement to ensure the evaluations provide adequate detail of how the resident is progressing.

An activities programme is managed and implemented by providing a variety of group and individual activities to meet the interests of the residents.

Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage. There were shortfalls identified in ensuring that residents who self-administer their medicines are assessed as competent to do so and the processes related to controlled drugs are consistently undertaken.

The menu has been reviewed by a dietitian as suitable for the older person living in long term care. The kitchen has recently been renovated and will be able to cater for the increased number of residents.

Safe and appropriate environment

<p>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.</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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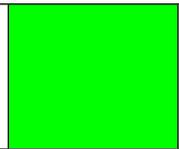
The service provider desires to increase its maximum resident capacity to 57 beds. A new wing with 12 bedrooms with ensuite bathrooms has been constructed since the previous audit. These rooms are considered suitable for dual purpose hospital or rest home level care. Seven residents were residing in this wing on the day of the audit. Refurbishment of an old wing to convert three bedrooms to four bedrooms is under construction. The addition of extra rooms will reduce the current practice of accommodating three hospital residents in one bedroom.

An increase in resident numbers will not impact the systems in place for waste management. Strategies are yet to be implemented to meet increased demand in cleaning services and a potential increase in demand for laundry services. There is a requirement to ensure the new external areas are safe and suitable for use by older people.

There is a high risk requirement that a trial fire evacuation be completed in the new wing within a week. There is a requirement to obtain an approved fire evacuation scheme from the NZ Fire Service which takes into account the new building areas.

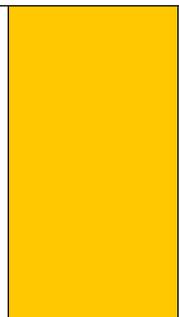
Otherwise the new extension is safe and suitable for occupation.

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.
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There are six residents who have bed rails in place as a restraint for safety reasons. These have been assessed, consented and monitored and are being applied according to the standards. On the day of audit there are no enablers in use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The previous area for improvement to ensure there is an infection control programme that is reviewed at least annually still requires implementation. The service also needs to ensure the infection control programme includes any changes that are required for the new extension and increase in resident numbers. Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated, analysed and trended. Actions are implemented to reduce infections when trends are identified.

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	17	2	3	5	0	0
Criteria	0	44	2	3	10	1	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service is managing its complaints process and the complaints register contains information about the two complaints received since the previous audit. 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 interviewed confirmed knowledge of the ways to lodge a complaint.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The previous area for improvement at criterion 1.1.2.3 required the service to have an admission agreement that includes identifying additional costs, this is now addressed. The new admission agreement includes a process for identifying any additional costs which the resident may incur. The admission agreement and the Code of Health and Disability Services Consumers' Rights (the Code) is explained as part of the admission process. Admission agreements are signed in the resident's files. The residents and family interviewed reported that the admission agreement and Code is part of the admission process.
Standard 1.1.9: Communication	FA	Review of staff meeting minutes, residents' meetings and incident and accident reports and interviews with staff and residents reveal that there are regular opportunities for communication to occur. There is an open disclosure policy. Incident reports indicated when and who has been notified about an adverse event. Feedback

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>from residents and their families reveals satisfaction with communication.</p> <p>There is an interpreter policy but no residents who have required interpretation services.</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>PA Low</p>	<p>The 2015 business plan includes values, and scope but no goals. There is no indication in the current business plan that additional rooms were being added. The general manager stated these will be developed with the owners in July at an annual business meeting.</p> <p>The general manager has been in the role for seven years and has a nursing background. The manager stated on audit day that there was minimal support from the owners in regards to the new building project.</p> <p>Partial Provisional</p> <p>The general manager was not aware of the requirements or the process for approval to increase the service capacity. The Waikato DHB portfolio manager was not advised or consulted before building work commenced and residents had been moved in to the new wing prior to obtaining approval from the MoH. There has been no notification to the NZ Fire Service that building changes have occurred which effect the approved fire evacuation scheme and a trial fire evacuation did not occur prior to residents occupying the new wing.</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>The registered nurse/clinical coordinator is the delegated acting manager during the general manager's absence. This role is shared with the administrator. The administrator was not available for interview. The general manager stated there has been no interruption to service delivery during the manager's absence.</p> <p>Partial Provisional</p> <p>There is no indication the increase in capacity will impact this standard.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>PA Moderate</p>	<p>The quality policy and the quality plan do not describe the quality system. There is no clear, systematic or coordinated approach to monitoring service delivery or quality. The quality plan does not belong to the organisation and consequently the content is not service specific. There was no evidence that the quality objectives are being monitored for progress. Bi-monthly audits of the laundry and the kitchen are being carried</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>out by the staff in those areas, otherwise there was no regular service delivery checks being conducted.</p> <p>The previous area requiring improvement is resolved as there is now a policy on the management of policies. It states these will be reviewed every two years. In practice all policies are being reviewed annually by the general manager. There is a revision sheet attached to each policy which records what if any changes or amendments have been made.</p> <p>Quality improvement data is not defined or identified and subsequently is not used for monitoring services. Incident and accident data is collated monthly and displayed in the staff room. Staff meeting minutes do not record any discussion about quality improvements or the quality data that is being collected. The clinical coordinator and the kitchen and laundry staff are involved in service delivery monitoring in terms of conducting regular audits but there is no evidence the results of these are shared or used for making service changes...</p> <p>Clinical risks to residents are assessed by the clinical coordinator and the RNs. These are documented in residents' records. The risk management plan identifies common risks and hazards are being reported according to the staff interviewed. Staff, residents and the one family member interviewed stated they had no concerns about service delivery which was consistent with the feedback received from a recent resident/relative survey.</p> <p>Partial Provisional</p> <p>The service provider does not meet the standard for quality and risk. There are requirements to implement a clear and coordinated quality system.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>The staff meeting records show that the manager is aware there have been events which are not recorded or reported (e.g., skin tears). Apart from meeting minutes there is no other follow up or actions documented to show that these matters are now resolved. The event records reviewed on the day of the audit contain sufficient detail about the incident. There is no evidence that preventable events are investigated to determine cause and prevent or minimise recurrence. The event forms record where GPs or family have been notified.</p> <p>There have been no known serious events. The manager did notify the MoH about a disgruntled ex-staff member and is waiting on a police investigation about a suspected theft from a resident before notifying the DHB. There is a non-compliance in criterion 1.2.1 related to the non-notification of service changes to the DHB or MoH.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Review of personnel records, including recently employed staff, showed that recruitment processes include interviews, reference and police checks. A professional recruitment company has been used in the past to</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>recruit professional staff.</p> <p>The clinical coordinator oversees new staff orientation. Orientation documents indicated that information about all areas of service delivery, including emergency protocols is shared with new staff. Each new staff member is allocated a buddy to work with until the new staff are considered competent and safe to work alone. A recently employed RN confirmed the orientation process provided sufficient information and support to carry out delegated tasks.</p> <p>The service provides regular ongoing training in the safe care of older people to staff. An annual training plan is documented. Education is primarily in-service education sessions provided by the clinical coordinator or physiotherapist. A group of healthcare assistants (HCAs) confirmed that the service supports staff to engage in regular training and upskilling. Long term HCAs have achieved New Zealand Qualifications Authority (NZQA) qualifications, level three core competency in the National Certificate Health, Disability and Aged Support. All the RNs and the activities coordinator are maintaining first aid qualifications. The RNs' personnel records contained copies of current practising certificates. Annual performance appraisals have occurred for all but four staff. Appointment times and pre work had been completed for these to occur. The previous area for improvement has been resolved.</p> <p>Partial Provisional</p> <p>The increase in capacity will not affect the systems in place for recruitment and management of staff.</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>There are two RNs 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 contract requirements. The service uses a ratio of four HCAs and an RN rostered for work in the hospital wing when there are more than 16 hospital level care residents. On the day of audit there are three HCAs in the hospital for the morning shift and three in the afternoon. There were two HCAs in the rest home for the morning and afternoon shift. 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. Agency staff are used to cover gaps in staffing. An extra RN was called in to assist on the day of audit and was on site within 30 minutes. Interviews with staff and observations reveal there were enough hours allocated for cleaning and laundry and activities. Staffing meets the contract requirements.</p> <p>Partial Provisional</p> <p>The general manager has considered staffing requirements to meet the needs of an additional 10 residents has recruited more HCAs and will be increasing the number of HCAs rostered on each shift if resident numbers increase. Discussions had occurred with housekeeping staff and a strategy is agreed to allocate extra cleaning hours although this is not currently implemented. (Refer CAR 1.4.6.2). Laundry services are not yet impacted as resident numbers were less than the current maximum occupancy on the day of audit. Laundry staff state that</p>

		the equipment and processes in place will cope with increased demand.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The previous audit identified improvements were required to the standing orders, the use of electrolytes and medicine charts; these have been addressed. There are new issues identified related to the controlled drug register, signature verification and competency assessments for residents who self-administer their medications.</p> <p>Medicines are supplied by the pharmacy in a pre-packed administration system. The nursing staff review the medications delivered for accuracy against the medicine charts. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists. Safe medication administration was observed in the rest home and hospital during the audit.</p> <p>The medicines and medicine trolley were securely stored. The temperature of the medicine fridge is recorded daily, with most of the sighted temperatures within medicine storage guidelines. There were some readings that were just below the required temperature, though this does not reflect a systemic issue.</p> <p>All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. All of the medicine charts have been reviewed by the GP in the past three months.</p> <p>Medication competencies were sighted for all staff that assisted with medicine management.</p> <p>Partial Provisional Audit: The service does not require making changes to the medication management systems with the increase of residents.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service has a four week rotational menu with summer and winter variations. The menu has been reviewed by a dietitian within the last two years as being suitable for the residents.</p> <p>Residents are routinely weighed at least monthly and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The residents and family/whanau report satisfaction with the meals.</p> <p>The kitchen service has six monthly external inspections by the council. All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. The kitchen staff have completed safe food handling training and ongoing education.</p> <p>Partial Provisional Audit: The kitchen staff report that the kitchen has been recently renovated to be able to cater for the increased number of residents. The kitchen staff also report that there has been a planned discussed to increase food holding equipment and staffing in the kitchen when the service has reached its full</p>

		capacity.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	The previous audit identified that improvements were required to the short term care planning. All residents' files reviewed evidenced individualised short term plans for temporary needs. However, there is a now a new area for improvement as the care plans did not clearly describe all the supports and interventions required.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Staff were able to describe the interventions implemented for the residents (see criterion 1.3.5.2 regarding the documentation of these on the care plan). The residents and family report that interventions are consistent and meet their needs.
Standard 1.3.7: Planned Activities 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.	FA	There are planned activities provided five days a week. The activities programme covers physical, social, recreational and emotional needs of the residents. There were diversional therapies, activities, social and cultural assessments sighted in the residents' files. The activities programme is also linked to the exercise and interventions implemented by a visiting physiotherapist and onsite physiotherapy aid. Feedback is sought from residents at the residents' meeting and during activities. The activities coordinator reported that they gauge the response of residents during activities and modified the programme related to responses and interests. Activities are modified according to the capability and cognitive abilities of the residents. The residents reported satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a	PA Low	Evaluations of care are conducted at least six monthly; however, there is insufficient detail included in the care evaluations. Where progress was different from expected, the service responded by the use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed. The residents and family member reported satisfaction with the care provided.

comprehensive and timely manner.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policy related to management of waste meets the requirements and the service was recently audited by an environmental consultancy company that analysed their trade waste in the kitchen and laundry. This was a requirement subsequent to installation of a new kitchen grease trap. Test results were within limits. Incontinence products are being disposed of in lined buckets and then bagged separately for transfer to outside bins. There have been no incidents of blood or body spill in the past 18 months. The addition of the 10 extra beds is not anticipated to impact on the established procedures for waste management. An adequate supply of personal protective equipment was observed to be on site and in use by all staff on the day of the audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Negligible	<p>The building warrant of fitness (BWOFF) expires on 17 June 2015. There is evidence that plant and equipment are being maintained (e.g., hoists, scales and electrical equipment). The new wing has grab rails installed in the ensuite bathrooms and in the corridors.</p> <p>A Code Compliance Certificate was issued for the new wing on the 28 April 2015. The new bedrooms and ensuite are of sufficient size to accommodate hoists and more than one person to assist with lifting and mobilisation. New carpet flooring was being installed on the day of the audit in a corridor and the dining room has been refurbished with new flooring and furniture.</p> <p>The main access in and out of the building is via a ramp. The external door in the new wing is a fire exit and flushes with the ground. New external environments include a decked sitting area. There is no seating, shade or railings installed. This area is not in use.</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</p>	FA	<p>Each of the twelve new bedrooms has an ensuite with toilet and accessible shower. The old wing which is being reconstructed will retain its communal bathroom and toilet for four bedrooms.</p>

attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	The 12 new bedrooms are complete with new furniture which includes single beds, bed side cabinets, an easy chair and clothes storage units. The rooms are of an adequate size to accommodate mobility aids and allow at least two people to assist in resident lifting or manoeuvring. With the addition of 12 single bedrooms and the reconstruction of a three room wing to four bedrooms the current practice of having three hospital residents in one room will be minimised or reduced to two beds shared rooms.
<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	The existing dining room adjacent to the new wing has been refurbished with new floor carpet, drapery and paint. New dining tables and chairs are in use. The area is spacious and can accommodate up to 20 residents seated at tables. Hospital residents are supported with eating whilst sitting in lounge chairs in the existing lounge. An increase in resident numbers has been provided for.
<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>	PA Negligible	<p>Laundry staff conduct resident satisfaction surveys at regular intervals and use the feedback received to make changes or improvements if required.</p> <p>Interviews with the housekeeper and laundry staff confirmed that strategies have been agreed to increase cleaning hours to incorporate the extra wing and new rooms. No changes have been made to laundry hours or processes as there has been no impact at this stage. Resident numbers are under the current approved capacity of 47 residents.</p>
<p>Standard 1.4.7: Essential, Emergency,</p>	PA	There has been no notification of building changes to the NZ Fire Service and therefore the evacuation scheme has not been amended. There is new fire suppression and alarm system in place and staff verified they have

<p>And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>Moderate</p>	<p>been informed about the new system. A trial evacuation was scheduled to occur the week after this audit.</p> <p>The building has an emergency lighting system installed. Cooking is powered by gas and electricity, there is an outside barbeque and gas cylinders are kept full. Water storage has been increased by the installation of a new water tank and pump in anticipation of demand as a result of increased bed numbers. Maintenance staff are storing potable water but the quantity could not be verified as staff were not available and the storage area was locked. The civil defence kits sighted contains necessary supplies. There are adequate stocks of food onsite.</p> <p>The new call system was checked on the day of the audit and found to be functioning.</p> <p>Security procedures now include the new wing; checking of the wing that is currently being rebuilt.</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 areas in the facility have good sized windows and doors that open to the outside for ventilation. Corridors and bedrooms in the new wing have electric panel heaters installed. The temperatures in this wing were comfortable on audit day. All other areas in the home are heated by electricity. Two of the six residents interviewed commented they were feeling cold. Outside doors were open at the time and it was a particularly cold day.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>PA Moderate</p>	<p>The previous audit identified that the infection control programme is required to be reviewed at least annually; this has not yet been implemented. There are policies and procedures regarding infection prevention and control that have been reviewed with in the last 12 months. There is not a documented infection control programme in place.</p> <p>The infection control coordinator has a job description for the role that includes lines of accountability and communicating results to the manager. There is infection prevention and control activities conducted, which include monthly surveillance, staff education and a monthly infection control committee meeting. The infection control committee review the infection surveillance data.</p> <p>The infection control coordinator has undertaken appropriate education and will seek specialist services from the DHB and contracted infection control advisors when required.</p> <p>Hand sanitising gel was located at the entrance and throughout the facility. There are processes in place to prevent residents, staff and visitors spreading infections. Staff were aware of their responsibilities for infection prevention and control.</p> <p>Partial Provisional Audit: When the infection prevention and control programme is developed this will need to</p>

		include what infection prevention and control practices will be required in the new extension and current renovation of rooms. The infection control coordinator confirmed there will be appropriate resources including personal protective equipment and clothing for all staff use as required with the increase to resident numbers
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	The service conducts monthly surveillance for infections. There is a monthly infection control meeting with any recommendations discussed at the staff meetings. The infection and surveillance data for 2015 recorded analysis and evaluation of the infection surveillance data. Where there were increases in infections the service implemented actions to reduce the infections and prevent further infections.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	There are six residents who have bed rails in place for safety reasons. On the day of audit there are no enablers in use. The policy complies with the standard. Review of the restraint register and resident records and interview with the clinical coordinator show that there is understanding of the requirements of this standard. Staff knowledge about restraint minimisation is tested by the completion of questionnaires at least bi annually.

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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	The 2015 business plan includes values, scope and direction but no goals. The general manager stated these will be developed with the owners in July at an annual business meeting.	The 2015 business plan does not include goals and there is no evidence that business plans are regularly reviewed.	<p>Develop measureable goals for the business and review progress against these regularly.</p> <p>180 days</p>
<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>	PA Moderate	The quality policy does not relate to the quality plan and neither the policy nor the quality plan describes a quality system. The general manager stated the quality plan was sourced from the internet. The objectives in the plan are generic and not service specific.	The quality policy and the quality plan do not describe the quality system. There is no clear, systematic or coordinated approach to monitoring service delivery or quality. The clinical coordinator and the kitchen and laundry staff are involved in service delivery monitoring in terms of conducting	<p>Establish a quality system that is suitable to the size and scope of the service. Implement the system and ensure all staff understand and are involved in its implementation.</p> <p>90 days</p>

			regular audits.	
<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>The quality plan does not refer to any of the processes in place for monitoring service delivery; for example, the laundry and kitchen audits and equipment checks. The quality objectives in the plan are general and do not include clear quality indicators. A recent resident, relative satisfaction survey has been conducted and feedback is being gathered. Results from this do not indicate any concerns.</p>	<p>It is not clear how service delivery is linked to the quality management system because the quality system is not described.</p>	<p>Establish a quality system which reliably measures and monitors service delivery.</p> <p>90 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>The quality policy and the quality plan do not identify what quality improvement data is. There are some aspects of service delivery being monitored but the outcomes of these are not reliably analysed or used to make service improvements (See CAR in 1.2.4). Apart from monthly incident totals being displayed in the staff room, there is no evidence that staff are informed about service delivery trends or when and how quality improvements are to be made.</p>	<p>The quality policy and the quality plan do not identify what quality improvement data is, or how service delivery is monitored, evaluated and communicated.</p>	<p>Document what the service considers to be quality improvement data. Develop systems for collecting, analysing and evaluating data to identify where improvements are required. Implement effective ways of informing and involving staff in quality improvement matters.</p> <p>90 days</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is</p>	<p>PA Moderate</p>	<p>The quality plan is not service specific and the quality objectives are not being monitored for progress.</p>	<p>There are no processes for measuring achievement against the quality and risk plan</p>	<p>Develop quality objectives that are measurable and measure accordingly.</p>

implemented.				90 days
<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>	PA Moderate	There are limited systems for objectively identifying where improvements are required. No plans for improvement have been documented for a number of years. The staff meeting minutes record a number of issues that need addressing but no strategies for rectifying these. There is no documented process for ensuring that corrective actions are carried out.	There are no corrective action plans in place. Areas requiring improvement are not being reliably identified or recorded.	<p>Develop systems to measure where improvements are required. Document the actions required to remedy these and then monitor that actions are implemented</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	The event records reviewed during the audit contained sufficient detail about the incident. However, there is no evidence that preventable events are investigated to determine cause and prevent or minimise recurrence. Incident data is collated but this is not analysed or discussed at RN or HCA meetings.	The manager sees incident and accident reports but there is no evidence that these are reviewed or investigated or that consideration goes into preventing recurrence. Incident data is collated but this is not analysed or discussed at RN or HCA meetings.	<p>Ensure all incidents are evaluated to identify where service improvements can be made. Identify key performance indicators for incidents and compare results month by month to track trends. Discuss the information being gathered from incident reports with staff.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and</p>	PA Moderate	<p>The controlled drugs are securely stored in a safe. Each administration of the controlled drugs is signed by two staff. There is evidence of a six monthly reconciliation and stock count of the controlled drugs. The weekly check of the controlled drugs was not consistently conducted, with two weeks between some of the record checks.</p> <p>The medicine charts have a signature verification</p>	<p>The weekly stock count of the controlled drugs is not consistently documented.</p> <p>The signature verification was not completed on all the medicine charts.</p>	Provide evidence that the weekly controlled drug check is consistently conducted and signature verification is documented on the medication administration chart.

medicine reconciliation in order to comply with legislation, protocols, and guidelines.		section at the bottom of the signing sheets. All medicine charts did not record the signature verification of the staff who have administered medications.		90 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	The three files of residents who self-administer their medications did not evidence a competency assessment that indicated the resident was suitable to self-administer their medicines. These files do have a consent form, though no competency assessment. One of the resident's files does have a GP progress note entry that records they feel the resident would be suitable for self-administration, although there is no other assessment that has been reviewed at least three monthly.	There is no competency assessment evidenced for the residents who self-administer their medicines.	Provide evidence that residents are assessed as competent to self-administer their medicines and this is reviewed at least three monthly. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	The care plans reviewed have a format that includes documenting the required interventions as identified through the ongoing assessment process; however not all the interventions required were documented. In three of the five files reviewed there were not clear interventions or ongoing assessments for all issues related to weight loss, falls minimisation strategies, pain and wound care. The care staff were able to describe the interventions that are implemented, despite these not always being recorded on the care plan.	Not all care plans describe the interventions required.	Provide evidence that all the interventions required are clearly documented in the care plan. 180 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement	PA Low	One of the five residents' files documented an evaluation that described how the resident was responding to interventions and progressing towards meeting their goals. The Other four files recorded the evaluation of care by a date and	Not all evaluations are detailed.	Provide evidence that evaluations are documented and indicate the degree of achievement or response to interventions, and

or response to the support and/or intervention, and progress towards meeting the desired outcome.		signature of the staff, with no other detail recorded.		progress towards meeting the desired outcome. 180 days
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	PA Negligible	Access to new external areas has been created with the creation of a new wing. These are not currently in use and do not have seating, shade or railings installed.	The new deck areas are not complete with furniture, shading or barrier rails	Ensure the new deck area(s) is made safe and comfortable for resident use with appropriate furniture, barrier railings and shading. Prior to occupancy days
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	PA Negligible	Discussions had occurred with housekeeping staff and a strategy is agreed to allocate extra cleaning hours although this is not currently implemented. Laundry services are not yet impacted as resident numbers were less than the current maximum occupancy on audit day. Laundry staff state that the equipment and processes in place will cope with increased demand.	No changes have been made to cleaning or laundry services. Strategies have been agreed for housekeeping/cleaning hours to increase to meet the extra demand but these are not yet implemented. Laundry services have not been impacted by the change.	Ensure there are sufficient hours of work allocated to cleaning and laundry to meet the demands of 10 extra residents. Prior to occupancy days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and	PA High	There is new fire suppression and alarm system in place and staff verified they have been informed about the new system. A trial evacuation was scheduled to occur the week after this audit.	Staff have not participated in a trial evacuation using the new system or including the new environment.	Ensure all staff participate in a trial evacuation that includes the new wing. 7 days

emergency procedures.				
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	<p>PA</p> <p>Moderate</p>	<p>There has been no notification of building changes to the NZ Fire Service and therefore the evacuation scheme has not been amended.</p>	<p>The approved evacuation scheme does not include the new wing.</p>	<p>Submit an application for amendment to the fire evacuation scheme and obtain approval for this.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	<p>PA</p> <p>Moderate</p>	<p>An infection control programme was not sighted. The infection control coordinator is newly appointed to the role and has started to develop the infection control programme, but this has yet to be documented.</p>	<p>There is no clearly defined and documented infection control programme that is reviewed at least annually.</p>	<p>Provide evidence that the infection control programme is developed, implemented and reviewed at least annually.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.