

Lifecare Cambridge Limited - Lifecare Cambridge

Introduction

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

The audit has been conducted by 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 March 2018 End date: 29 March 2018
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:	43

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 Ltd provides residential respite services, and rest home and hospital level care to a maximum of 59 residents. There were 43 beds occupied on the day of this unannounced surveillance audit. The manager stated there have been no changes to the scope and size of the services provided since the 2016 certification audit.

This audit was conducted against a subset of the Health and Disability Services Standards and the provider's contract with the Waikato District Health Board (WDHB). Additional standards criteria were verified by request of a portfolio manager. These are responded to in the relevant standards.

The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, family members, management, staff, the contracted physiotherapist and a pharmacy technician. The general practitioner (GP) who is most available 'on call' was interviewed by telephone. This person confirmed there is an agreement in place with Lifecare to be available on call 24 hours a day, seven days a week. This GP expressed satisfaction with the care and services being provided.

Eight of the nine areas requiring improvement from the previous certification audit (in quality and risk management, consumer records and infection control) have been addressed. One area related to evaluation of corrective actions remains open. Three new areas of noncompliance were identified. These concern an overdue interRAI assessment, medicines management and safe storage of chemicals.

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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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The complaints process Code of Health and Disability Services Consumers' Rights. The manager stated there have been no written complaints received. A complaint from a family member to the Office of the Health and Disability Commissioner in early 2017 was investigated and not substantiated.

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 low risk.
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The service has implemented a new quality and risk management system which is working well for them and there is regular monitoring of all service areas.

Adverse events are reported by all levels of staff. People impacted by an adverse event are notified (for example, general practitioners, other clinicians and families). Systems that ensure regulatory requirements related to notification reporting are effective.

Staff are recruited and managed according to good employment practices. Staff training in relevant subject areas is occurring regularly. All staff are supported and encouraged to attend ongoing performance development and achieve educational qualifications related to care of older people.

There is an adequate number of skilled and experienced staff on site 24 hours a day seven days a week

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.		Some standards applicable to this service partially attained and of low risk.
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that safely meet the needs of the residents and contractual requirements.

Residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides 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 has been approved by a registered dietitian. Residents' 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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current building warrant of fitness and all interior and exterior areas are being maintained as safe.

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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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and four restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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>Standards applicable to this service fully attained.</p>
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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	4	0	0	0
Criteria	0	41	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that apart from the complaint to HDC in February 2017 there have been no written complaints received since the previous certification audit in 2016. The HDC investigation into a complaint from a family member in early 2017 was not substantiated.</p> <p>The facility manager is responsible for complaints management and follow up. The manager described receiving verbal concerns from families which were followed up and improvements made. Evidence of this was seen in meeting minutes. It was suggested that verbal concerns be also recorded in the complaints register. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents</p>

<p>provide an environment conducive to effective communication.</p>		<p>being able to speak English.</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>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of reports to the directors/owners showed adequate information to monitor performance is reported including occupancy, audit results, quality data and emerging risks and issues.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for ten years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at forums, seminars and conferences relevant to the age care sector.</p> <p>The service holds contracts with WDHB for residential respite, rest home and hospital services. Eight residents were receiving medical and hospital services, and 34 rest home and respite care at the time of audit. One resident was off site in Waikato Hospital. All residents were over the age of 65 years.</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 Low</p>	<p>The organisation has purchased and implemented a comprehensive and sector specific quality and risk system that reflects the principles of continuous quality improvement. This includes all policies and proforma for quality and risk plans, care plans, tools for management of incidents and complaints, audit activities, resident and family satisfaction surveys, monitoring of outcomes, and guidelines and tools for clinical incidents including infections, wounds and pressure injuries and restraint.</p> <p>The system automatically populates inputted data for benchmarking with other care facilities. The owner of the system is providing ongoing support and guidance.</p> <p>The acquisition and effective use of the new quality system, verifies that five improvements required from previous audit which were related to quality and risk are now resolved. There is a well described and facility specific quality ad risk plan with goals that are monitored for progress, all quality data is automatically collated and categorised for easy analysis by the system and meeting minutes show that the results are being shared with staff. Lifecare Cambridge is following the system schedule for internal audits of all service areas and applying the audit tools built into the system with good effect. These are helpful for staff to easily identify service shortfalls.</p> <p>The improvement required in criterion 1.2.3.8 is ongoing. Although corrective actions are developed and implemented there is a failure in evaluating the effectiveness of the corrective actions to ensure the noncompliance has been addressed.</p>

		<p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and risk/health and safety team meetings, RN and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and training in the policies and procedures. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents reports reviewed showed these were recorded clearly, that causative factors were identified and then isolated, minimised or eliminated where possible. These were being signed off by the facility manager (sometimes on the same day they occurred) without any evidence that corrective actions had been effective. Refer to the improvement required in criterion 1.2.3.8 regarding implementing and evaluating corrective actions. Adverse event data is now collated, analysed for month by month trends and reported at quality/health and safety and RN and staff meetings. This data is now being benchmarked with other care facilities around the country.</p> <p>The facility manager understands essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, or WDHB since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the</p>

		requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</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>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. No personal or private resident information was on public display during the audit.</p> <p>The previous audit identified an area for improvement to ensure that all documents related to residents contain uniquely identifying information. This has been addressed and records were available to demonstrate this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A paper-based system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were not within current use by dates. Clinical</p>

		<p>pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>The required three-monthly GP review was consistently recorded on the medicine chart. No residents were self-administering medications at the time of audit. Good prescribing practices were not always evident for all resident's medication charts which included the prescriber's signature and date recorded on the discontinuation of short course medicines and all requirements for pro re nata (PRN) medicines.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 food service is provided on site by one of three cooks and kitchen staff and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The facility operates with an approved food safety plan and registration issued by the local city council and expires 8 February 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The facility also provides 40-50 daily 'meals on wheels' for clients in the community and are delivered by volunteers.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident. One 'house doctor' interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. The facility is supported by a total of</p>

<p>adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>nine GP's who visit from five medical centres in Cambridge. The general manager interviewed stated that all GP's hold an afterhours component but if the resident's GP is unable to be contacted after hours the facility will call the after-hours medical centre in Hamilton and seek advice.</p> <p>Registered and care staff confirmed that care was provided as outlined in the documentation and that they have after hours support from either the general manager/RN or clinical nurse leader. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' 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 activities programme is provided by one activity co-ordinator. The activities co-ordinator support residents Monday to Friday from 8.30am to 4.00pm. After hours and in the weekends, staff have access to activities and integrate daily living with activities while supporting residents.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities are offered at times when residents are most physically active and/or restless and the activities calendar remains flexible to accommodate the residents' day to day preferences. The facility offers a van trip three times a week. Families interviewed confirmed they find the programme excellent and stimulating for the residents.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes and updates to the care plans. This was observed at the time of audit for the five residents' files reviewed. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and challenging behaviours. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 16 June 2018) is publicly displayed in the foyer of the main entrance.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		<p>equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</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>	<p>PA Low</p>	<p>Visual inspection revealed at least four chemical bottles (for example, deodorizer and a high strength cleaning product) hanging off the handrails throughout the facility. Two other bottles were also found in one of the communal shower rooms. These were immediately removed. .</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The portfolio manager requested that this audit verify that all call bells are in place and working and that there is a contingency plan in place for instances in which a call bell is 'out of order'. Visual inspection and staff interview revealed that a faulty call bell had been identified (via staff carrying out routine checking) in the days leading up to audit. This had been attended to by an electrician who took the bell away for parts and repair. A replacement call bell was installed. On the day of audit, the replacement call bell faltered and the electrician was recalled immediately. The resident was provided with a hand held bell and all staff were informed.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p> <p>The previous audit identified an area for improvement to ensure that the infection control nurse/coordinator completes infection control education. This corrective action has now been addressed and evidence was provided showing that the infection control nurse attended external training for infection control in April 2017.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of eye, skin/soft tissue, influenza, urinary tract infection (with or without an indwelling catheter), lower and upper respiratory tract infections, and gastroenteritis. The IPC coordinator/registered nurse reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular registered and care staff meetings and at staff handovers. Trends are identified from the past year and this is reported to the staff, clinical nurse leader and general manger. The previous audit identified an area for improvement to ensure that a method was developed and implemented to accurately collect and compare infection information. The corrective action is now addressed</p> <p>The facility has had a total of 65 infections since July 2017. Three residents have been identified with frequent infections due to co-morbidities. The three residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of audit, four residents were using restraints (bed rails) and one resident was using a bed rail as an enabler. These were the least restrictive and used voluntarily at their request. A similar consent and assessment, and monitoring process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</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 1.2.3.8</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</p> <p>Moderate</p>	<p>All of the incident reports reviewed were being signed off as complete with little or no evidence that investigation and/or corrective actions had been taken to prevent recurrence. Internal audit reports reviewed, recorded the corrective actions taken where needed, but there was no follow up to ensure the service deficit or noncompliance had been resolved. This was validated by this audit revealing the same deficit in medicines management that an internal audit conducted by the service had revealed in 2017.</p>	<p>Not all corrective actions are being evaluated to ensure they are effective.</p>	<p>When a noncompliance is identified (via incidents, internal audits or complaints) implement corrective actions, then check/evaluate that the corrective actions taken have remedied the problem.</p>

				60 days
<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 medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>The GP and pharmacy technician interviewed stated that the care provided for residents and communication between parties was excellent. An internal medication management audit dated 1 December 2017 and six-monthly pharmacy audit dated the 13 March 2018 highlighted that not all residents' medication charts meet medication guidelines and legislation and corrective actions were implemented to address the issues. At the time of this audit three separate eye drop medications were prescribed for the one resident and were being administered, however the medication expired on the 14 December 2017 (more than 30 days after the opening of the medication). All other medicines reviewed were within their use by dates. The two mentioned audits also highlighted that not all resident medication charts meet medication guidelines and legislation and corrective actions were implemented to address the issues. At the time of this audit 14 residents' medication paper-based files were reviewed. Five medication charts (which included seven individual medications), did not have short course medication signed off by the GP. Four medication charts (which included 11 individual medications) did not have reason stated for pro re nata (PRN) medications. One medication chart for a short-term medication did not have the length of time documented.</p>	<p>Not all medication administered to residents were used within the required timeframe, have short course medication signed off by the GP, have reason for use of pro re nata (PRN) medication documented or have length of time documented for use of short term medication.</p>	<p>Provide evidence that all medicine and medicine management information is recorded and administered to comply with legislation, protocols and guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided</p>	PA Low	<p>All residents have individual details and client specific initial care plans and long-term care plans. Residents have an interRAI assessment completed by one trained interRAI assessor on site. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process. The facility was able to show email evidence requesting transfer of the residents file however on the day of audit the file was yet to be transferred to the facility from DSL and the resident did not have an up to date interRAI assessment completed.</p>	<p>One resident admitted to the facility on the 16 January 2018 has not had an interRAI assessment. The facility is awaiting transfer of the file from</p>	<p>To provide evidence that all residents have an up to date interRAI assessment.</p> <p>180 days</p>

within time frames that safely meet the needs of the consumer.			Disability Support Link (DSL).	
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	<p>PA Low</p>	<p>Visual inspection revealed at least four chemical bottles (for example, deodorizer and a high strength cleaning product) hanging off the handrails throughout the facility. Two other bottles were also found in one of the communal shower rooms. These were immediately removed. .</p>	<p>Chemicals are being left in areas where visitors or residents could access; they are not being stored securely</p>	<p>Ensure that all chemicals are stored in secure areas when they are not in use.</p> <p>30 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.