

Cambridge Resthaven Trust Board Incorporated - Cambridge Resthaven

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:	Cambridge Resthaven Trust Board Incorporated
Premises audited:	Cambridge Resthaven
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 26 June 2018 End date: 26 June 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:	68



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

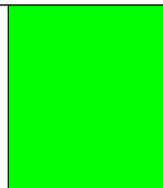
Cambridge Resthaven provides rest home, hospital and dementia level care for up to 80 residents in the care facility and another 12 apartments are approved as suitable for the occupant to receive rest home level care. The service is operated by Cambridge Resthaven Trust Board Incorporated and managed by a CEO, a general manager and two clinical nurse leaders. There have no significant changes since the previous certification audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the Waikato District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner. Residents, their families and the general practitioner spoke positively about the care provided.

This audit identified two areas requiring improvements. These relate to the integration of documented care and medicine reconciliation. There is a rating of continuous improvement for achievements in governance. Improvements have been made to the processes for evaluation of care which addresses the area requiring improvement at the previous certification audit in 2016.

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.



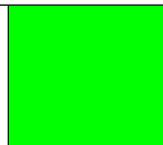
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively

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.



Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility, with oversight.

The quality and risk management system includes internal audits, and the collection and analysis of quality improvement data. This data is benchmarked with seven other facilities and identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

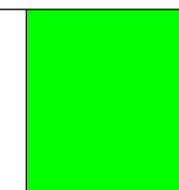
Care plans are individualised, based on a range of comprehensive information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. Two facility vans are available for outings.

Medicines are managed according to policies and procedures and are consistently implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses or senior care staff, all of whom have been assessed as competent to do so.

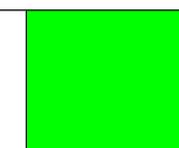
The food service is managed on site by an external contractor and meets the nutritional needs of the residents with special needs catered for. Policies guide food service staff who have food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness.

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 which support the minimisation of restraint. There were twelve restraints and enablers in use at the time of audit.

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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Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	14	0	1	1	0	0
Criteria	1	36	0	1	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 policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The complaints register reviewed revealed there are, on average, 12 complaints and compliments received each month. The provider had notified the DHB about two of these and invited a local consumer trust to be involved, due to the complexity of the matters. There were detailed accounts of actions taken, through to an agreed resolution. Acknowledgements and investigations were completed within acceptable timeframes. Action plans showed any required follow up and improvements have been made where possible. The general manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no known complaints to the Office of the Health and Disability Commissioner since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to 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>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Staff knew how to access interpreter 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>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 monthly reports to the trust board showed adequate information to monitor performance is reported including emerging risks and issues.</p> <p>The service is managed by a general manager (GM) who holds education qualifications and has been in the role for nine years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through a post with the regional chapter of the NZ Age Care Association and regular meetings with other facility managers in the Community Trust Care Association (CTCA) group. CTCA is part of a business entity comprising eight aged care facilities who share common factors, such as being located rurally and governed by not for profit organisations. This has led to improvements in business operations and resident care.</p> <p>The service holds contracts with Waikato DHB for hospital-geriatric, rest home, dementia, medical and respite care with a maximum capacity of 80 beds, plus 12 apartments that have been approved as suitable to deliver rest home care. On the day of audit there were 68 residents on site. Twenty-four were assessed as hospital level care, this included three people under the age of 65 and three with long term care conditions, and 33 rest home residents. One of these was short stay/respite and one resident living in an apartment was receiving care. Eleven residents were in the memory enhancement unit.</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</p>	<p>FA</p>	<p>The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. The system includes management of incidents, infections and complaints, audit activities, regular resident and family satisfaction surveys, internal audits and the monitoring of outcomes. Where areas for improvement are identified these are documented and actions are monitored for implementation.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality data and benchmarking with seven other age care facilities. Information is reported and discussed at the weekly senior management team meeting, and regular health and safety, quality and risk team meetings, registered nurse (RN), health care assistant (HCA) and general staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The GM notifies all staff of corrective actions or policy/process changes electronically. Resident and family satisfaction surveys are completed annually and there</p>

improvement principles.		<p>had been no significant issues in recent feedback.</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>There is a current risk management plan which is monitored by the CEO and the Board. The GM described 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 incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff. Falls, urinary tract infections, skin tears and hospital admissions are benchmarked with the seven other facilities who belong to CTCA. Review of the comparative data showed no significant variations or trends for Resthaven in the areas benchmarked.</p> <p>The GM understands essential notification reporting requirements, including for pressure injuries. A section 31 notification was submitted for a pressure injury in 2018, but it was later discovered the wound was not caused by pressure. There have been no notifications to public health or other significant events such as police investigations, coroner's inquests, or issues-based audits.</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</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 six 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. There is a dedicated staff educator who ensures staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. This includes,</p>

legislation.		the level 4 dementia modules for staff working in the memory enhancement unit. All RNs have this level 4 certificate. There are five RNs who are maintaining their annual competency requirements to undertake interRAI assessments. The staff educator is an approved interRAI trainer and the general manager has management access. 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	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, for the number of residents and their needs including residents who require care in the serviced apartments. There are adequate staff available to replace when there are unplanned absences. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage.
<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 safe system for medicine management using an electronic system 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. These medications are not checked by a RN against the prescription on arrival to the facility. Interviews verify that this is not a process in place at Cambridge Resthaven. All medications sighted were within current use by dates. Clinical pharmacist input is provided onsite every six months and verified by documentation.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. 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>Good prescribing practices noted include the prescriber's electronic authorisation and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The</p>

		<p>required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were three residents who self-administer medications at the time of audit. Documentation and interviews verify appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and clinical nurse leader (CNL) and the General Manager (GM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</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>	FA	<p>The food service at Cambridge Resthaven is provided by an on-site contractor. The food service is managed by a qualified chef 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 in October 2017. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and had a verified audit undertaken in March 2018. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction and some dissatisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. An initiative to provide the main meal in the evening is in the process of being implemented. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p> <p>The residents in the secure unit had access to food always. The kitchenette in the unit is restocked weekly by the cook, with perishables supplied daily. Staff, residents and family members verified food was available always.</p>
Standard 1.3.6: Service	FA	Except for those mentioned (refer criterion 1.3.3), 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

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>meeting a range of resident's individualised needs was evident in all areas of service provision. The general practitioner (GP) interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined at verbal handovers rather than documentation in the care plan. A resident with a pressure injury and another with a wound had comprehensive documentation identifying the interventions required that evidenced effective management strategies for these residents. 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 a trained diversional therapist (DT), supported by three assistants, two of whom are currently participating in diversional therapy training.</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. This review is noted in the resident's progress notes. The resident's activity needs are evaluated regularly, however a formal review is not recorded as part of the six-monthly care plan review (refer criterion 1.3.3.4)</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included involvement with the local schools, kindergartens, music therapy sessions weekly, visiting entertainers, quiz sessions and daily news updates.</p> <p>The activities programme in the secure unit is developed by the DT and is run by the healthcare assistants (HCAs) working in the unit, with the assistance of the DT. The residents from the unit, often participate in the activities programme operating in other areas of the facility. All residents in the unit have a twenty-four-hour activities plan, that identifies residents' interests and their assessed routines.</p> <p>The activities programme was verified to enable the needs of residents under 65 years to be met. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to.</p> <p>Ten residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan reviews occur every three months for residents deemed stable, with a documented evaluation</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>occurring six monthly in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. A previous corrective action request identified the long-term care plans were not evaluated to indicate the degree of achievement in response to the intervention. This has been addressed and evaluations were sighted around the interventions documented in the care plan. Except for that referred to in criterion 1.3.3.4, where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short term care plans being consistently reviewed for infections, wound care, pressure injury management, weight loss, and progress evaluated as clinically indicated. Residents and 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, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current Building Warrant of Fitness (BWOFF) due to expire on 12 May 2019. Buildings, plant and equipment are being well maintained and were in a safe condition.</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, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control co-ordinator (ICC) and the two clinical nurse leaders (CNLs) review all reported infections. 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 the CNLs and RNs at the daily meetings, and with staff via staff meetings and at staff shift handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>The restraint register is being maintained as was current and accurate. On the day of audit there were 12 residents using bedrails and lap belts for safety reasons and/or to promote independent mobilisation. The service applies the</p>

Services demonstrate that the use of restraint is actively minimised.		same assessment, consent, monitoring and review processes for all safety interventions whether they are voluntary or not. A sample of two residents' records and observations confirmed that restraint documentation and the use of devices complies with this standard.
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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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage,</p>	PA Low	<p>A review of the medication management system identified there is no system in place to ensure the monthly medications dispensed by the pharmacy are checked on site by an RN to ensure it matches the medication order.</p> <p>Observation at the medication round verified medication is checked against the prescription prior to administration to the resident.</p> <p>Medications at Cambridge Resthaven are administered by either a RN, enrolled nurse (EN) or a team leader (TL) who is a senior HCA, all who have been deemed competent in medication administration.</p> <p>Evidence verifies there is no system operating at Cambridge Resthaven that requires the medications delivered to the facility to be checked by a RN against the prescription. Interviews and observation of a medication round evidenced each medication pack was checked against the prescription prior to administering the medication to the resident.</p>	The facility does not have a process in place to ensure all medications provided to the facility from the pharmacy are checked on arrival by an RN to ensure it matches with the medication order.	Evidence is provided to verify medications delivered to the facility are checked by a RN against the medication order.

disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				30 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Moderate	<p>A review of seven residents' files identified a number of residents assessed needs and the required interventions not documented in the care plan.</p> <p>The service is co-ordinated so that a comprehensive verbal handover, including written handover data is passed on at the change of each duty. In addition, each resident's care plan is documented by a RN who is allocated to manage the care of that resident. However, a review of files identified continuity of care cannot be assured as the documentation to guide that care in three of the seven files reviewed was not reflective of the resident's needs.</p> <p>A resident in the secure unit has frequent episodes of challenging behaviour, and a behaviour management plan is in place. A behaviour monitoring chart captures numerous episodes of challenging behaviour; however, the management strategies being used by staff during these episodes are inconsistent with the behaviour management strategies documented in the care plan. Specialist advice has been sought, with management strategies suggested (as evidenced by reading the specialist's report and interview with the clinical nurse leader). Verification of the commencement of these strategies is evidenced by interviews and documentation around medication management. Improvement in behaviour is evidenced by a reduction in challenging behaviour episodes, observation, progress notes, staff and family interviews. The care plan makes no reference to input by specialist services, the findings, the management strategies implemented, and the monitoring required to enable ongoing assessment of the effectiveness of the strategies. Interview with the resident's family identifies the family member as having high regard for the care provided by staff at Cambridge Resthaven. The family member was kept well informed and involved in the process to manage the resident's care. Interviews with staff in the secure unit, verifies an understanding of behaviour management strategies, an improvement in the resident's behaviour and the reasons behind that improvement.</p> <p>A rest home resident living in an apartment with a history of epilepsy and on anticonvulsants has no reference in the care plan to the potential risk of fits and</p>	<p>The documentation in the care plans of three of the seven care plans reviewed did not identify all the residents assessed needs and the required interventions needed to manage or monitor those needs. Documentation, interviews and observation did not evidence a co-ordinated approach that could demonstrate continuity of care was being delivered.</p>	<p>Provide evidence the care plans are reflective of the residents needs to enable a co-ordinated approach to resident care and continuity in the care provided.</p> <p>90 days</p>

		<p>management strategies to be implemented if these occur. Interview with the resident verified a prompt response to a call for assistance after a recent fall, and satisfaction with the care provided by staff of Cambridge Resthaven.</p> <p>A resident in the hospital has a chronic condition necessitating complex pain and/or anxiety management, with the medication orders being flexible, to enable the resident to be kept pain free. No evidence of regular pain monitoring was sighted, other than a three-monthly review. An interview with a RN identified inconsistencies in how often to use pain relief versus the use of anti-anxiety medications. The residents frustration around having to wait for pain relief medication to be administered, was highlighted at interview. The care plan does not identify the specifics of a planned approach to managing the resident's pain, based on what regime is deemed effective.</p> <p>The care plans reviewed did not ensure a co-ordinated approach to meeting the residents' activity needs as there was no reference to ongoing review of activities as part of the care plan. This was verified by interview with the diversional therapist. Any changes around activities are recorded in the residents' progress notes, but not as part of the care / activity plan.</p>		
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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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>	CI	<p>Cambridge Resthaven combined with seven other aged care facilities in the wider Waikato community who are governed by charitable trusts and formed a company, Community Trust Care Association (CTCA) in 2014. The aims of the Trust are to work collaboratively and share resources in ways that sustain and support the individual trusts (eg, bulk purchase of products and supply agreements, benchmarking and information systems). A recent evaluation has proved cost savings, for example \$35,000 saved in continence supplies over a three-year period. Qualitative measures include enhancing all directors' professionalism and overall improved governance, and gains from providing peer support for a range of employees who were previously working in isolation, for example, activities staff, clinical managers, and facility managers. The group is also working together to share methods and resources for staff education which has improved the frequency and calibre of ongoing staff training. There is now monthly benchmarking of adverse events which benefits each service by providing them with comparative data and using group intelligence to identify how to halt unwanted trends and replicate favourable trends. The group company received a finalist's award for Business Innovation by an International Forum (Eldercare Innovation Awards) in 2017.</p>	<p>The benefits resulting from the formation of CTCA have been evaluated and proven using qualitative and quantitative measures. Residents have benefited from ideas for different activities generated at activities meetings, improved performance of clinical nurse managers who feel more supported in their roles and an increase in other staff</p>

			skills and knowledge.
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End of the report.