

# Lifecare Cambridge Limited - Lifecare Cambridge

---

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Lifecare Cambridge Limited

**Premises audited:** Lifecare Cambridge

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 2 July 2019 End date: 3 July 2019

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 49

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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 level care for up to 57 residents. The facility is owned by Lifecare Cambridge Limited and is managed by a general manager. Residents and families spoke positively about the care provided.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, a general practitioner and a pharmacist.

Areas requiring improvement relate to the management of clinical governance, reporting quality data to staff, position descriptions, orientation for staff, competencies for second checkers relating to controlled drug management, medication competencies for registered nurses, restraint competencies for clinical staff, performance appraisals for registered nurses, unique identifiers on residents' documentation and whiteout being used on a number of documents.

## 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.
--	--	--

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and 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.

There were no residents at the time of audit who identified as Māori. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents’ needs.

The general manager is responsible for the management of complaints and a complaints register is maintained.

## 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.
---	--	--

Lifecare Cambridge Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Lifecare Cambridge. Systems are in place for monitoring the service, including regular reporting by the general manager to the board.

The facility is managed by a general manager who has been in the position for 11 years. Support is provided by the board with regular contact by the chairperson.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement. Quality, health and safety, registered nurses, staff and residents' meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

An in-service education programme is provided and staff are encouraged to complete a New Zealand Qualification Authority education programme.

The documented rationale for determining staffing levels and skill mixes ensures staffing requirements are based on the needs of residents. Registered nurses are rostered on duty at all times. The general manager is on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

The facility has a policy to support safe medication management. Staff administering medication are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified 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.
--	--	--

A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents' rooms have adequate personal space provided. Lounges, dining areas and alcoves are available. External areas for sitting and shade are provided. An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

## 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.

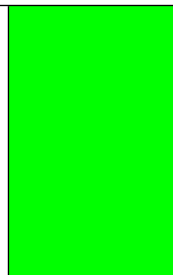


Standards applicable to this service fully attained.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There was one resident using restraint and residents using enablers at the time of audit.

## 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.



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken. 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)
<b>Standards</b>	0	46	0	2	2	0	0
<b>Criteria</b>	0	94	0	5	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form and admission agreement. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented, as relevant, in the residents' records. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits and phone calls from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<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). The information is provided to residents and families on admission and there is complaints information and forms available at the main entrance. All complaints have been entered into the complaints register. Two complaints were reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The general manager (GM) is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The GM reported there has been a complaint to the Health and Disability Commissioner Advocacy Service since the previous audit from a resident who was admitted for respite care. Documentation reviewed from the advocacy service evidenced two letters, the first setting out the complaint and the second stating the complainant did not want any further action to be taken. There have been no investigations by other external agencies since the previous surveillance audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	<p>FA</p>	<p>Residents and families interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission agreement and information provided and from discussions with staff. The Code is displayed in the main</p>

<p>Consumers are informed of their rights.</p>		<p>foyer/entrance area together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room or share one of five rooms with one to two other residents, with their consent.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The clinical nurse leader interviewed reported that there were no residents who affiliated with their Maori culture at the time of audit. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. Interviews with residents and families confirmed that the resident's individual culture, values and beliefs are being meet.</p>

their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, podiatrist, physiotherapist, audiology clinic, wound care specialist, the plastics and diabetes/renal departments at the local district health board, psychogeriatrician and mental health services for older persons. A general practitioner (GP), one of seven GP's from five supporting medical centres, confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included day to day discussions with residents and knocking on doors to ensure privacy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</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 knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. If required, staff can provide interpretation as and when needed with the support of family members.</p> <p>Two residents were identified as having a significant sensory impairment. Appropriate equipment, resources and allied support was evident in the residents' long-term care plans, for example, talking books, being supported when out in the community, ensuring knowledge of</p>

		someone's presence by knocking on the resident's door and introduction of one's self.
<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 Moderate</p>	<p>The business plan 2018-2020 is reviewed annually and includes a mission statement, business objectives, values, strengths, weaknesses opportunities and threats of the organisation. The governing board is made up of family members and meets formally four times a year. The chairperson meets with the general manager weekly. The general manager reported there is also frequent contact via phone at least three to four times a week to discuss all activities relating to the facility. The general manager attends the board meetings and presents reports relating to but not limited to quality data, financial performance, occupancy, staffing, training, complaints, audits and any risks.</p> <p>The general manager has been in the position for 11 years. The GM is a registered nurse who does not have a current practising certificate and is supported by the board. The GM keeps up to date attending various workshops, conferences and meetings. The clinical nurse leader(CNL) has been in the position for less than 12 months and has resigned from the position. The CNL is rostered full time on the floor as an RN and therefore there is no time available to carry out other responsibilities concerning the day to day clinical service.</p> <p>Lifecare Cambridge is certified to provide accommodation for 57 residents with 49 beds occupied on the first day of audit. All beds have been approved as dual purpose. There were 18 hospital level residents, 30 rest home level residents including one resident who is funded by ACC and one resident receiving respite services.</p> <p>Lifecare Cambridge has contracts with the DHB for aged related residential care services, long term chronic health conditions, and residential respite services.</p> <p>The general manager reported HealthCERT has been notified of the change of clinical nurse leader since the previous audit.</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>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the GM be absent. The GM stated the CNL would fill the position during the general manager's absence. Support would be provided from the administrator and the board.</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 a quality assurance and risk management programme including a quality framework that documents 11 quality goals and objectives.</p> <p>Quality data is being collected, collated and comprehensively analysed to identify trends. Corrective actions are developed and implemented with monitoring to ensure corrective actions have been effective. Registered nurse, staff, health and safety and resident meeting minutes reviewed evidenced they are held regularly. The RN and general staff minutes record numbers only. Registered nurses confirmed they discuss clinical indicators at their meetings. The health care assistants (HCAs) stated that analysis of data and any trends are not reported back to them. Although the electronic programme can generate graphs as part of the reporting to staff, they are yet to be provided. The interRAI/quality RN demonstrated sound knowledge relating to quality and risk management.</p> <p>Resident and family satisfaction surveys are completed yearly. The 2018/2019 survey showed residents and families are satisfied or very satisfied with the service provided.</p> <p>Policies and procedures are fully embedded at Lifecare Cambridge. They are relevant to the scope and complexity of the service, reflected current accepted good practice, reference legislative requirements and refer to interRAI. Policies and procedures are reviewed by the company who provides the system and were current. New / reviewed policies are available for staff to read and they are required to sign off these once read. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provided appropriate guidance for service delivery.</p> <p>Actual and potential risks are identified and documented. The risk register includes but is not limited to clinical, environment, staffing and financial risks. A risk matrix is used to rate the level of risk. The physiotherapy assistant is the health and safety representative and is responsible for the management of hazards, including putting in place appropriate controls to eliminate or minimise all hazards on site. Interview of the physiotherapy assistant confirmed this. Hazards are communicated to staff and residents as appropriate. The physiotherapy assistant demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</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</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by the RNs and health care assistants (HCA) on hard copy forms and reviewed by the GM. Information is entered into the electronic system by the interRAI/quality RN. The GM is responsible for the development of any corrective actions and close out. Review of the electronic register, incident/accident reports and interview of staff indicated appropriate management of adverse events.</p>

<p>family/whānau of choice in an open manner.</p>		<p>The electronic adverse events summary provides good analysis and trending and includes possible contributing factors identified. Where the incident occurred with monthly comparisons.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff are aware of essential notification responsibilities. The GM stated there has been one Section 31 notified to HealthCERT for a pressure injury since the last surveillance audit that was acquired prior to admission. The GM reported there have been no other notifications made to external agencies apart from the change in CNL.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Policies and procedures relating to human resources management are based on relevant legislation and good employment practices. Staff files reviewed evidenced employment agreements, references, performance appraisals and criminal vetting. Review of staff files evidenced not all staff have position descriptions including position descriptions for restraint and infection control coordinators, not all staff have completed an orientation and RNs performance appraisals have not been reviewed and signed by a registered nurse with a current practising certificate.</p> <p>The orientation programme is specific to the position description. The entire orientation process takes up to 10 days to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff reported the orientation process prepared them well for their role.</p> <p>The GM advised staff who have not completed a New Zealand Qualification Authority education programme are encouraged to do so. There are HCAs who have started the programme and other who have attained different levels. There is an assessor for the organisation.</p> <p>The education programme is the responsibility of the GM. Documentation evidenced in-service education is provided at least monthly following the staff meetings and during handover. Attendance is entered into individual registers.</p> <p>Competencies for medicine management are current for RNs, however, the competency for the CNL and another RN has been signed and dated by the GM who does not have a current practising certificate and does not have a medication competency. Restraint competencies were not evidenced. There was no evidence that the HCAs on the night shift have completed a competency for being a second checker of controlled drugs.</p> <p>Two RNs are currently interRAI trained and have current competencies, this will reduce to one</p>

		<p>RN once the CNL ceases employment. There is at least one staff member on each shift with a current first aid certificate.</p> <p>Annual practising certificates were current for staff and contractors who required them to practice.</p> <p>Staff interviewed confirmed they have completed an orientation. Staff also confirmed their attendance at on-going in-service education and that their performance appraisal was current.</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>	FA	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery including acuity, skill mix of experienced staff and less experienced staff.</p> <p>Registered nurse cover is provided 24 hours, seven days a week. The GM advised there is a casual pool of HCAs who can work at short notice. The GM reported the rosters are adjusted to meet the changing needs of residents, resident acuity including interRAI, occupancy and the environment.</p> <p>The GM works full time Monday to Friday and is on call after hours. Nine RNs, including the CNL are currently employed. Apart from two new graduates, one of which worked as an HCA prior to graduating, the RNs are experienced and have worked in the facility for a number of years. There was a range of HCAs interviewed who have been working at the facility from 12 years to several months. Review of the roster evidenced two RNs on the morning shift, one of which is the CNL, two RNs on the afternoon shift and one on at night.</p> <p>Residents, families and staff interviewed reported satisfaction with the staffing levels.</p> <p>There are dedicated cleaning and laundry staff. An activities coordinator is employed Monday to Friday. A maintenance person and administrator work five days per week. The kitchen has a chef working during the week with a cook on at the weekends and kitchen hands.</p> <p>Observations during this audit confirmed adequate staff cover is provided, including residents being helped with meals in a timely manner.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when</p>	PA Low	<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. Not all documentation was supported with a unique</p>



required.		<p>identifier and white out was identified on a number of organisational/management documents.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of two individual residents being recently transferred to the local acute care facility and showed good communication and documentation provided between staff at the facility, GP, family, acute hospital setting. Families of the two residents reported being kept well informed during the transfer of their relative.</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</p>	FA	<p>The medication management policy was 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 a paper-based 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</p>

<p>practice guidelines.</p>		<p>administer medicines have completed a medication competency and are competent to perform the function they manage but the competencies have not been signed by another medication competent registered nurse (refer to 1.2.7.5).</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 within current use by dates. Clinical pharmacist input is provided as required.</p> <p>The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering; however, night duty 'second checkers' for controlled drugs are not medication competent (refer to 1.2.7.5). The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and complied with guidelines. Vaccines are not stored on site.</p> <p>There was one resident who self-administered medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</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 a chef, one other cook and kitchen team 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. The menu was given a rating of 45 out of 50 (excellent rating).</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Waipa District Council which expires 8 February 2020. The facility had a Verification Audit on the 3 April 2019 with the overall outcome being acceptable and next due 2 November 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The Chef 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</p>

		<p>requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews and resident meeting minutes. 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 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments except for two recent admissions to the facility who are awaiting transfer of their files. The interRAI assessments are completed by one of two trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	FA	<p>Documentation, observations and interviews verified the 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 in all areas of service provision. The GP</p>

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care was 'excellent'. Care staff confirmed that care was provided as outlined in the documentation. 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 an activities co-ordinator who supports residents Monday to Friday 8.30 am to 4.30 pm.</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 daily and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. The activities co-ordinator visits each resident in the mornings to remind them of the activities for that day and to support one to one time for those residents that choose to stay in their rooms. Residents from both the rest home and hospital wing often join together to partake in activities that interest them. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme lots of fun and look forward to the bingo and regular entertainment.</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>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 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 to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Residents at the facility are supported by one of seven GP's that visit from the five</p>

<p>External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>local medical centres. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the diabetes clinic and mental health services for older persons. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Safe and appropriate waste management procedures including hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation, including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Health care assistants and the cleaner demonstrated good knowledge concerning waste and hazardous substances.</p> <p>Protective clothing and equipment including gloves, face visors and disposable aprons were observed appropriate to recognised risks.</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>A current building warrant of fitness is displayed that expires on the 17 June 2020. The facility is adequately maintained both internally and externally. A preventive and a reactive maintenance programme is implemented and hot water temperatures are within the recommended range. The maintenance person reported rooms are refurbished as needed. Testing and tagging of electrical equipment and calibration of biomedical equipment was current. A hazard and maintenance book are situated at eye level as staff leave the staff room and the health and safety representative stated this initiative reminds staff to make entries into the book. Review of the book evidence actions and sign off.</p> <p>There are areas throughout the facility for residents to frequent. Ramps with handrails provide easy access for residents, externally. Residents were observed to easily manage with mobility aids within the facility.</p> <p>External areas are well maintained with areas for residents to sit and there is shade.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>There is a mix of bedrooms with wash hand basin or full ensuite. Adequate number of showers and toilets are located throughout the facility. Engaged/vacant signage is in place for privacy.</p>

<p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>Residents and families interviewed reported that there were sufficient toilets and showers and that they are easy to access.</p>
<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	<p>The GM reported all rooms have been approved for hospital or rest home level care use (dual purpose). Bedrooms are large enough to provide personal space for residents and allow staff and equipment to move around safely. There are two bedrooms that accommodate three residents and three rooms that accommodate two residents. Curtains are appropriately installed that allow for complete privacy for all residents residing in the shared bedrooms. Residents confirmed they have requested to be in these rooms because they enjoy the company.</p> <p>Rooms are appropriately furnished and maintained. Residents interviewed spoke positively about their accommodation. There is room to store mobility aids.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents have areas within the facility to frequent, including dining and lounge areas that are easily accessed by residents. Residents can access areas for privacy if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents and families interviewed reported there are adequate areas for them to access and enjoy.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Dedicated laundry staff wash and dry all laundry on site using commercial equipment and cleaning of the facility is completed by dedicated cleaners. Both laundry and cleaning staff demonstrated sound knowledge of processes. Cleaning and laundry processes are audited for effectiveness as per the audit programme. Review of audits confirmed this. Chemicals are stored securely and were in appropriately labelled containers. The company representative visits monthly. Cleaning equipment and linen bags are colour coded for different uses.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and</p>	FA	<p>The evacuation scheme was approved by the New Zealand Fire Service in 1919. Documentation reviewed evidenced fire drills are completed six-monthly. There have been no structural alterations since the previous audit. The emergency plan details emergency preparedness. Staff confirmed their awareness of emergency procedures. The orientation</p>

<p>security situations.</p>		<p>programme includes fire and security training. All required fire equipment has been checked and is current.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and a gas BBQ. An underground water storage tank holds 2000 litres. The requirements meet the Ministry of Defence and Emergency Management recommendations for the region. Emergency lighting is provided. A call bell system alerts staff to residents who require assistance.</p> <p>The doors are locked in the evenings. Staff also complete security checks and there are sensor lights situated around the exterior of the building.</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>Heating is provided via heat pumps in communal areas and individual heaters in all the bedrooms. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All residents' rooms have natural light. The facility is smoke free within the building and there are external areas for smokers. Residents and families confirmed the facility is maintained at a comfortable temperature. During the audit, the temperature was appropriate in all areas.</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>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP as required. The infection control programme and manual are reviewed annually.</p> <p>The clinical nurse leader/registered nurse is the designated IPC coordinator but does not hold a job description related to the infection prevention and control role (refer to 1.2.7.3). Infection control matters, including surveillance results, are reported monthly to the general manager and tabled at the quality/risk committee meeting. This committee includes the general manager, clinical nurse leader, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance and two other doors that visitors/families access to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one year. She has attended study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in August 2018 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers and signs were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>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</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastroenteritis and other infections. The IPC coordinator/clinical nurse leader 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>



programme.		<p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Trends are identified from the past year. Results of the surveillance programme are shared with staff via regular registered staff meetings and at staff handovers, but this information is not reported back to all staff (refer to 1.2.3.6). Twenty-three (23) residents consented to the flu vaccine in April 2019.</p> <p>The facility has had a total of 57 infections from January 2019 through to and including June 2019. 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. Data is not benchmarked.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint and enabler policy includes definitions, assessments and evaluation and complies with the requirements of the standard. The restraint coordinator, who is the CNL, reported the aim is not to use any sort of restraint. Equipment is used so that restraint is not required. There was one resident using a restraint and five residents using an enabler. The files of the residents using a restraint and an enabler were reviewed and evidenced all required documentation was completed.</p> <p>Staff interviewed demonstrated sound knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint. Competencies for restraint minimisation and safe practice were not available at the time of audit. (Refer 1.2.7.5)</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The use of restraint is approved by the restraint approval group prior to commencing the restraint, this includes the resident's GP. An authorisation/consent form was sighted on the resident's file for the one person using restraint. Three-monthly reviews of restraints in use occurs. The restraint coordinator does not have a job description for the restraint coordinator on file (refer 1.2.7.3). Responsibilities of the restraint coordinator and approval group are clearly outlined.</p> <p>Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous</p>	FA	<p>The file of the resident using restraint was reviewed. A restraint assessment form was completed prior to commencing restraint. Risk factors were identified in the assessment and the purpose of</p>

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		the chosen restraint was documented. The long-term care plan documented any risk and desired outcomes. Staff demonstrated knowledge in maintaining culturally safe practice when completing assessments for restraint use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Policies and procedures are accessible for all staff to read. Safe use of restraint is actively promoted. There is a current and updated restraint/enabler register. Care plans included any risk factors and ensured the resident's safety while using restraint. Staff demonstrated knowledge about restraints and strategies to promote resident safety while using restraint. There were no restraint-related injuries reported. Monitoring forms are in place for all residents who are using restraint and enablers and these were completed as required.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Residents using restraints and enablers are evaluated at least six-monthly and the resident's care plan six monthly. Consents and evaluation forms were signed and dated. The evaluation form includes (a) to (k) of the standard and the effectiveness of the restraint and the risk is documented in the long-term care plans. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval group evaluated the restraints in use at least annually. Meeting minutes confirmed this.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint approval group is responsible for monitoring and reviewing restraint. Quality review of restraint is monitored through the internal audit programme. Identified issues are discussed at the staff meetings as well as additional education that is required to support staff. This includes education relating to restraint and challenging behaviour. Staff demonstrated good knowledge relating to managing challenging behaviours. The resident using restraint was a recent approval.

## 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 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	<p>PA</p> <p>Moderate</p>	<p>The general manager is a registered nurse who has not held a practising certificate for 12 years and has been in the position for 11 years. The GM's file evidenced attendance at various workshops, conferences and meetings including forums held at the DHB. The clinical nurse leader (CNL) has been in the position for less than 12 months and it is unclear following interviews with the GM and CNL what the lines of responsibility are concerning operational and clinical matters. The CNL is rostered on the floor as an RN full time, therefore there is no time available to carry out other responsibilities concerning the day to day clinical service as per the job description for clinical coordinator, sighted on the CNL's file. The CNL has resigned from the position. This current situation does not meet the ARRC Contract D17.4.ba.</p> <p>The GM stated during the audit that the position will be advertised along with a new RN position.</p>	<p>The general manager who is an RN does not hold a current practising certificate and the clinical nurse leader is not able to undertake responsibilities concerning the clinical service because the CNL is rostered on full time as an RN working on the floor.</p>	<p>Provide evidence that D17.4ba of the ARRC Contract between Lifecare Cambridge and the DHB, relating to the employment of a clinical manager is met.</p>

				60 days
<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>	PA Low	<p>Quality data including incident/accidents, satisfaction surveys, internal audits and infections is being collected, collated and comprehensively analysed to identify trends. The RN and general staff minutes record numbers only, including skin tears, falls, and infections. Registered nurses confirmed they discuss clinical indicators at their meetings and any trends. The health care assistants (HCA) stated that analysis of data and any trends identified is not reported back to them at their meetings.</p>	<p>Reporting of quality data, apart from numbers, was not evidenced in the RN and general staff meeting minutes. Although the RNs interviewed stated they do discuss any trends, the HCAs stated they are not provided with results including any trends.</p>	<p>Provide evidence that quality data including clinical indicators and trends are reported to all clinical staff and recorded in the meeting minutes.</p> <p>60 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>Employment agreements, references, performance appraisals and criminal vetting were evidenced on staff files. Although the restraint and infection control coordinators understood their roles, four of eight files reviewed including the restraint and infection control coordinators files did not evidence specific position descriptions to the roles.</p>	<p>Not all staff files reviewed evidenced position descriptions, including position descriptions for the restraint and infection control coordinators.</p>	<p>Provide evidence that all staff have position descriptions on file.</p> <p>60 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>The orientation programme has specific components depending on the position description. The entire orientation process, including completion of competencies, takes up to 10 days to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Although staff interviewed stated they had completed an orientation, four of the eight staff files reviewed did not have evidence of an orientation.</p>	<p>Not all staff files have evidence of a completed orientation.</p>	<p>Provide documented evidence that all staff have completed an orientation.</p> <p>180 days</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>There is a training programme that covers all essential subjects. The GM is responsible for the programme. Training is provided at least monthly following the staff meetings and during handover. Each staff member has an individual attendance register. External educators take some sessions and staff have the opportunity to attend sessions externally and are expected to share the information with the rest of the staff. Registered nurses have the opportunity to attend sessions provided by the local DHB.</p> <p>Staff are encouraged to complete a New Zealand Qualification Authority education programme. The GM reported there is a mix of staff who have started the programme and others who have completed different levels.</p> <p>Competencies for medicine management are current for RNs, however, the competency for the CNL and another RN had been signed and dated by the GM who does not have a current practising certificate and is not medication competent. The GM stated that the RNs assess their colleagues and then the GM signs and dates the competency. Although the CNL reported clinical staff have current restraint competencies, the competency assessments were not evidenced. There was no evidence that the HCAs on the night shift have completed a competency for acting as the second checker of controlled drugs. Two RN performance appraisals have been reviewed by the GM who does not hold a current practising certificate.</p>	<p>(i)Medication competencies for the CNL and one RN have been signed and dated by the general manager who does not have a current practising certificate and does not have a medication competency.</p> <p>(ii)Restraint competencies were not available for review.</p> <p>(iii)Performance appraisals for RNs have been reviewed and signed by the general manager who does not hold a current practising certificate.</p> <p>(iv)Health care assistants are checking controlled drugs on the night shift without a completed second checker competency.</p>	<p>(i)Ensure medication competencies for the CNL and all RNs are undertaken including sign off, by an appropriate person with a current practising certificate who has a current competency.</p> <p>(ii)Provide evidence that restraint competencies have been completed and are current.</p> <p>(iii)Ensure performance appraisals for RNs are reviewed and signed by appropriate person with a current practising certificate.</p> <p>(iv)Provide</p>
---	------------------------	--	---	---

				evidence that health care assistants rostered on the night shift have current second checker competencies for controlled drugs.  30 days
Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.	PA Low	On the day of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's initial admission record reviewed. The nine files viewed did not all have unique identifiers evidenced on all individual progress notes, short term care plans, multidisciplinary meetings, assessment and photos of residents' wounds identifying who the resident was.	The sample of residents' documents and resident files reviewed did not all contain unique resident identifiers on progress notes, short term care plans, multidisciplinary meetings, assessment and photos of residents' wounds.	Ensure that all individual documents related to residents have uniquely identifying information to identify who the resident is.  180 days
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Resident and staff documents were written and/or typed legibly. Evidence of white out to erase mistakes was evident on staff appraisals and interRAI request user access forms.	White out is being used in a number of organisational/management documents.	Ensure that white out is not used to erase wording on a legal document.

				30 days
--	--	--	--	---------

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

No data to display
--------------------

End of the report.