

Cambridge Resthaven Trust Board Incorporated - Cambridge Resthaven

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: 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: 12 September 2019 End date: 13 September 2019

Proposed changes to current services (if any): For five of the bedrooms that were previously included in the dementia unit as being suitable for multiple purpose use. All five beds would either be used for secure dementia level care or all beds used for rest home and / or hospital level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 74

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

Cambridge Resthaven Trust Board Incorporated - Cambridge Resthaven, provides rest home, hospital and dementia care services for up to 80 residents in the care facility. In addition, there are 12 apartments that are suitable for the occupant to receive rest home level care. There are 20 bedrooms in the secure dementia unit. Five of these rooms are located where they can be safely included in either the secure dementia unit or used for rest home or hospital level care, by changing which door is activated for security. This is a change since the last audit when these bed spaces were used only for the provision of dementia level care. At the time of audit these rooms were being used for hospital and rest home level of care. All other beds, except five rooms are suitable for the care of either rest home or hospital level of care residents. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management, staff and two general practitioners.

This audit has resulted in the identification of one area requiring improvement. This relates to hot water temperature monitoring.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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 was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. 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 resident's needs.

Residents and families understood the complaints process and felt able to make a complaint or provide feedback/compliments to staff if they needed to. 'Help us help you' forms are readily available to residents and family. Complaints, concerns and suggestions are investigated and responded to in a timely manner.

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.

The strategic 'roadmap' has been developed by the chief executive officer and the board of directors. This document along with the quality and risk plan details the purpose, vision, values and aims/goals of the organisation. The general manager is responsible for ensuring services are provided to meet residents' needs, legislation and good practice standards with the support of the clinical nurse leader and the registered nursing staff.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, complaints management, incident/accident reporting, corrective action planning, benchmarking with other facilities, hazard identification and management, infection control data collection and conducting staff and resident/family satisfaction surveys. Quality and risk management activities and results are shared appropriately with management and staff. Corrective action planning is documented.

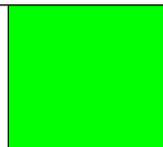
Recruitment and employment practices align with current accepted practice. New staff have an orientation relevant to their role. Staff participate in regular and relevant ongoing education opportunities. All applicable staff and contractors maintain current annual practising certificates.

The service has a documented rationale for staffing. There is always at least one registered nurse on duty who is called the triage nurse. Cambridge Resthaven registered nurses now work in a self-managing model of care. They have flexible work hours, however, remain responsible for oversight of designated residents ongoing care. Residents and family members confirmed during interview that all their needs and wants are met.

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 registered nurses, physiotherapists, activities team and general practitioners, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Twenty-four hour dementia care plans were in place. 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.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Snacks are available for residents on a 24-hour basis. 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.		Some standards applicable to this service partially attained and of low risk.
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Cambridge Resthaven facilities meets the needs of residents and was well maintained, clean and tidy. There was a current building warrant of fitness and electric equipment is tested as required. Communal and individual spaces are maintained with appropriate heating at an even comfortable temperature. External areas are appropriate and well maintained, with seating available. There is a secure external area for residents in the dementia unit. Appropriate shade is available.

Waste and hazardous substances are well managed. Staff are well protected with adequate supplies of personal protective equipment being available. Chemicals are stored safely. Laundry is contracted offsite and evaluated for effectiveness.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly. Residents reported a timely staff response to call bells. Security is well maintained.

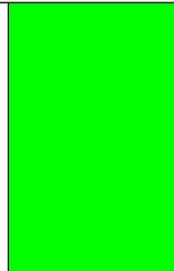
Restraint minimisation and safe practice

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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Policies and procedures are available for staff on the use of enablers and restraint minimisation practices. The facility has been restraint free since the last audit. There were no restraints in use during the audit. Ten residents had enablers in use. Staff are provided with education on restraint minimisation and use of enablers during orientation and the ongoing education programme.

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, 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	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Cambridge Resthaven 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>RNs and healthcare care assistants (HCAs) interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Residents in the dementia unit had activated EPOA's who have signed the admission agreements and the general consent forms. Records were sighted in the reviewed files and interviewed family confirmed being involved. 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 and/family representative 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 from residents' family 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>Cambridge Resthaven implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family and staff reported their understanding of the complaints process and noted they had no complaints. "Help us help you" forms are present throughout the facility and include an area for the recording of problems, suggestions and compliments. All resident and family concerns or complaints are documented. Since 4 July 2019 there have been 13 compliments and 24 concerns / problems logged. This included missing items of personal property which were subsequently located the same or next day.</p> <p>A complaints register is maintained. There have been no complaints received from the Ministry of Health or Health and Disability Commissioner, or District Health Board since the last audit. A review of six complaints verified they have been acknowledged, investigated and responded to in a timely manner. On occasions the general manager has sought input from Waikato District Health Board (WDHB) clinicians in relation to complaints received.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff on admission. The Code is displayed at the entrance to the facility 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 during provision of personal cares throughout the audit. Most residents have a private room. When a room is shared it is with a resident who is their spouse or another person with both resident's consent (refer to 1.4.4).</p> <p>Residents are encouraged to maintain their independence by participating in community activities and arranging their own visits to the doctor if desired. 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. Interviewed residents and families reported that there has been no suspected or witnessed abuse and neglect.</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>Residents in the service who identify as Māori are supported by staff to integrate their cultural values and beliefs and these were included in the care plan where required. Documentation was sighted in reviewed records. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers and the Accident Compensation Corporation (ACC) guidelines on Maori cultural competencies for providers. Guidance on tikanga best practice is available. Cultural training is provided to all staff as part of orientation and the ongoing education programme. Interviewed staff demonstrated awareness of the specific cultural needs of the residents who identify as Maori and individualised support was provided as per care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents and families interviewed verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met. Education on cultural safety is provided to staff on orientation and on an ongoing basis as per the education plan.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>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. 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>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioners (GPs) 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 the nurse key worker initiative where each nurse has residents and a GP allocated to them and they take overall responsibility of the team of residents allocated to them. Interviewed GPs, residents and families reported satisfaction with this arrangement as it provides one key nurse to communicate with and that the process has effectively improved communication for all parties involved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's health 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 and the use of family members if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	<p>FA</p>	<p>The strategic roadmap has been developed by the board of directors (BOD). This document along with the quality and risk plan details the purpose, values, scope, aims and priorities of the organisation. The service is managed by a chief executive officer (CEO) who has been in the role for approximately 17 years and is responsible for the overall Cambridge Resthaven Trust activities. The CEO reports to a board of directors.</p>

<p>appropriate to the needs of consumers.</p>		<p>There are currently seven members of the board.</p> <p>The services provided within the aged related residential care services at Cambridge Resthaven are overseen by the general manager (GM) who is a registered nurse. She has been in the role for over ten years and holds a post graduate diploma in management studies. The GM's responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM has exceeded eight hours of education per annum related to managing an aged related residential care facility as required by the providers contract with Waikato District Health Board (WDHB). The GM and the CEO provide monthly reports to the BOD. The sample of reports sighted included information to monitor performance, including occupancy rates, staffing numbers, emerging risks and issues, incidents and accidents, concerns, compliments and complaints, health and safety and equipment / facility issues.</p> <p>Cambridge Resthaven is one of eight facilities that have formed a Community Trust in Care Aotearoa (CTCA). These aged related residential care services work together to share information, education opportunities, policies and procedures, and purchasing buying power. The CTCA members meet regularly.</p> <p>The facility has an Aged Related Residential Care Contract with WDHB for the provision of rest home, hospital and dementia care services. There were sixty five residents receiving care under this contract. Thirty at rest home level, 14 at dementia level and 21 at hospital level care. A contract is also in place for the provision of respite services. There are three residents receiving rest home services under this contract. There is a Young People with Disabilities (YPD) contract with the Ministry of Health for the provision of rest home and hospital level care. There were four residents receiving care under this contract, two at both rest home and hospital level of care. There is a Long Term Conditions Chronic Health Contract (LTC CHC). One resident was receiving hospital level care under this contract. Since November 2018, Cambridge Resthaven has a service agreement with WDHB for the provision of rest and recuperation (R&R) services. There was one resident receiving short stay services under this agreement. There was a total of 74 residents receiving care at 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>When the GM is absent, the clinical nurse leader (CNL) is responsible for oversight of clinical services with the support of the CEO and registered nurses. The CNL works a minimum of forty hours a fortnight and is experienced in aged care nursing.</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>FA</p>	<p>Cambridge Resthaven has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, benchmarking, health and safety reporting, hazard management, infection control data collection and management, and concerns, compliments and complaints management.</p> <p>Cambridge Resthaven undertakes an annual resident and family satisfaction survey. This is undertaken by an external company and results benchmarked with other providers. This enables the resident / family to independently give their perspective from year to year for established questions. The external company provides the analysed results and information to enable internal comparison of the results from year to year as well as on how the service compares with peers. Targeted quality improvement projects are being undertaken in response to findings.</p> <p>A rolling 'team engagement pulse survey' (staff satisfaction survey) is conducted by an external company with several questions asked each month and reported on monthly, with an overall accumulative summary report provided at least annually. This provides a formal ongoing process to monitor staff perspective about their workplace. In addition, another company visits weekly and provides an opportunity for staff to have confidential discussions on any work or personal issues or concerns. These two programmes are aimed and enhancing the wellness and wellbeing of staff and giving staff a timely voice.</p> <p>A range of quality improvement data is also benchmarked monthly with the other seven aged related care services in the CTCA. This includes falls with and without associated injury, pressure injuries, urinary tract infections and skin tears - numbers reported per 1000 bed days. The GM reviews data and quality improvement projects implemented where applicable. In 2019, Cambridge Resthaven commenced participation in another quality indicator programme to further evaluate falls data, rates and trends over time.</p> <p>This is a restraint free facility. The restraint and enabler register sighted with information since May 2013 does not include any restraints in use. Regular internal audits are conducted, which cover relevant aspects of service including aspects of care, documentation and medicine management.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions have been developed and implemented. Quality information is shared with staff via shift handover as well as via the monthly staff meetings. The minutes of staff meetings are made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations / policies. Quality and risk activities and outcomes are also discussed at the weekly 'all team' meetings, where all services are represented. Operational and quality and risk issues are discussed at this meeting, and monthly at the health and safety meeting.</p> <p>Meetings are held with residents on a monthly basis to obtain resident feedback on food and the activities /</p>
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		<p>diversional therapy programme. The minutes of three meetings were sighted.</p> <p>Policies and procedures were readily available for staff. These have been developed by an external consultant and localised to reflect the needs of Cambridge Resthaven When changes are made by the consultant to policies / procedures, an email communication is sent to the GM manager with details. One paper copy of policy and procedure documents is available for staff. Copies are also available electronically for staff. The general manager is responsible for document control processes. Policies and procedure are discussed where applicable during the staff education programme.</p> <p>Actual and potential hazards / risks are identified in the hazard register. The hazard register and mitigation strategies have been recently reviewed. Organisation risks are documented in the quality and risk plan. The board of directors is currently reviewing how risk is documented and monitored at a governance level.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.</p> <p>Applicable resident events are being reported, since the 1 July 2019, electronically in a timely manner via the resident electronic record system. Events are disclosed with the resident and/or designated next of kin. This was verified by residents and family members interviewed. Medication and staff injury / health and safety events are still being reported via paper based systems. A review of reported events including falls, skin tear, two medication errors, a pressure injury, a near miss event, and staff injuries demonstrated that incident reports are completed, investigated and responded to in a timely manner.</p> <p>Staff advise they communicate incidents and events to oncoming staff via the shift handover. Events have been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted. The triage registered nurse on duty is responsible for investigating events reported during their duty. The electronic system includes communicating to the GM the number of open events. Currently the GM is the only person able to close out the incident / event. Data on all reported events can be readily obtained per resident or for a specified period of time. This includes the resident identification details, date and time of the event, location and staff reporting the event. Nursing staff noted the information is very useful and accessible to inform resident interRAI evaluations.</p> <p>The service benchmarks fall, pressure injury, and other clinical indicator rates with seven other aged residential care facilities (per 1000 occupied bed days). Refer to 1.2.3. The GM advised a total of four essential notifications to the Ministry of Health have been made by Cambridge Resthaven since the last audit in relation to pressure injuries present on admission, with one worsening since admission. One event was subsequently determined not to be a pressure injury, but another type of wound. The GM can detail the other type of events that require reporting. There have been no events that required reporting to the</p>

		Coroner.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes completing an application form, interview, referee checks, police vetting, and validation of qualifications and practising certificates (APCs), where required. The job description / employment contract includes a statement advising staff of privacy / confidentiality requirements. A sample of staff records reviewed confirmed that policies are being consistently implemented and records retained. All employed and contracted registered health professionals (RHP's) have a current annual practising certificate (APC). A register is maintained of these details.</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 showed documentation of completed orientation or new staff are working towards completing the requirements.</p> <p>A staff education programme is in place with in-service education identified and several opportunities and topics are provided every month.</p> <p>Care staff are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are currently at least five staff with foundation level two, 27 staff with a dementia care related qualification, eight staff with a level three qualification, and three staff with diversional therapy qualification. There are currently seven staff enrolled and/or working towards completing a dementia care qualification, four staff working towards a level three qualification (with two additional staff on hold), three staff working towards a level four qualification, and one staff member completing the diversional therapy qualification. The staff educator is an approved assessor and interRAI trainer and provides some training for the other CTCA facilities. The team leaders are reported to have a level four qualification.</p> <p>At least an annual one on one meeting (performance appraisal) is required for all staff. These were current in all randomly selected staff files reviewed.</p> <p>There are four volunteers that assist with the diversional therapy and activities programme, under the oversight of the diversional therapy team. They are required to complete an application form, are interviewed, police vetted, and complete an orientation programme and records are maintained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staff working in the dementia unit have completed a dementia care related industry approved qualification or are working towards this as required</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>to meet the provider's contract with WDHB (refer to 1.2.7.5).</p> <p>The clinical nurse leader (CNL) works 40 hours a fortnight. There is a staff educator (SE) who is an approved interRAI trainer. Nine out of the ten registered nurses and the staff educator have current interRAI competency.</p> <p>In addition to the GM, CNL and SE there are ten registered nurses employed. There are 38 health care assistants, five team leaders (one is an enrolled nurse), five housekeepers, one laundry staff member, five activities / diversional therapy staff, two maintenance staff and six members in the administration / corporate team. Laundry services are provided off site. The catering and cleaning services are provided by contractors.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. The GM monitors resident numbers, and level of care and reports on staffing to the board monthly. There is always at least one registered nurse on duty, who is called the triage nurse. The triage nurse is responsible for short term resident admissions, checking the administration of specific medicines and monitoring residents who are unwell. The triage nurse normally works up to three days in a row. In addition to completing a set number of triage shifts on the roster, the registered nurses are working as self-managing practitioners. The RNs have responsibility for between 8-10 residents in a 'keyworker' role. They are required to ensure all assessments and care plans are completed and updated, wound care is provided, GP routine reviews are conducted and communication with residents and family is timely. The RNs can work flexible hours of their choice in their 'keyworker role' so long as they work their number of contracted hours and their allocated residents care needs are being met. This new system was implemented in early 2019. Email feedback from family members sighted was positive and RN satisfaction and RN turnover rates have reduced.</p> <p>Health care assistants are rostered to work in designated areas. There is always a minimum of one caregiver in the dementia unit and two caregivers in the hospital and rest home areas including overnight. Additional caregivers are rostered in the morning and afternoon to ensure sufficient staffing to meet residents' care needs.</p> <p>The GM is normally on call when not on site. Staff report 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 three weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency staff are rarely used and when applicable and are provided with an orientation to the service and key policies and procedures at the commencement of their first shift.</p> <p>The four volunteers that assist with the diversional therapy and activities programme work under the oversight of the diversional therapy team.</p> <p>At least one staff member on duty (the registered nurse) has a current first aid certificate. Diversional</p>
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		therapy staff involved with taking residents on outings also have a first aid certificate.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Cambridge Resthaven is transiting to a new electronic resident management system with the integration of electronic activities care plans the next aspect to be included. Assessments, care plans and day to day cares documentation were being completed electronically by all disciplines including the nursing team, GPs, activities and physiotherapist. Paper based individual resident activity plans had been removed from the current paper-based records in use by staff, however, were present in another paper based record located in the same office. The facility does not consider any documents are archived until the resident is discharged.</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. Level of care records from NASC were sighted in the reviewed files. The admission process is managed by the RNs, clinical nurse leader (CNL) and the general manager (GM). 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 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. Where required, for example, for residents in the dementia unit, admission agreements were signed by the EPOA's. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort provided 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</p>

<p>planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>family/whānau. The key nurse worker is responsible for following up on residents when they are transferred to acute services with the help of the liaison officer. 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 as was sighted in records reviewed. A family member of a resident transferred to the acute care hospital 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 practice guidelines.</p>	<p>FA</p>	<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 and paper-based system for short term stay residents was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range.</p> <p>Good prescribing practices noted include 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.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if required.</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,</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor and is in line with recognised nutritional guidelines for older people. The menu follows six-weekly summer and winter cycles and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p>

<p>fluids and nutritional needs are met where this service is a component of service delivery.</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 Ministry of Primary Industries. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Fridges and freezer temperatures are monitored and recorded daily. Records were sighted. The food services manager is a chef and has completed a safe food handling qualification, with kitchen assistants completing relevant food handling training. The training records were sighted.</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. Snacks and drinks are provided for residents in the dementia unit on a 24-hour basis. Special equipment, to meet resident's nutritional needs, is available.</p> <p>The kitchen and pantry were clean. Decanted food was labelled with dates and covered. Cleaning schedules were in place and implemented. The food procurement system is in place and is managed by the head chef.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family interviewed, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough 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>	<p>FA</p>	<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.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented on the electronic system using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity and nutritional screening, 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 completed by 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>	<p>FA</p>	<p>Care 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>Triggers and interventions for identified behaviours of concern were documented in the care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities, 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 appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The services provided to residents are adequate and appropriate to meet the residents' assessed needs and desired outcomes as verified by interviewed residents and families. Advice is sought from other health providers or external health agencies where appropriate to ensure adequate support is provided. Referral documents were sighted in reviewed files. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GPs interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is implemented promptly. Interviewed care staff confirmed that care provided as outlined in the documentation. A range of equipment and resources were 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 three trained diversional therapists holding the national Certificate in Diversional Therapy (DT) and two activities assistants, one of whom is undergoing DT training. The activities team attend regular workshops and other meetings related to planning and providing meaningful activities.</p> <p>A social assessment and history is completed on admission to ascertain residents' needs, interests, abilities and social requirements by the DTs. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated when residents' ability and needs change and as part of the formal six-monthly care plan review. The service is transitioning to electronic care plans. Individual resident's activity plans and 24-hour activity plans were present in the paper based records (refer 1.2.9). Staff interviewed in the dementia unit were able to detail the interventions required for individual residents to keep them occupied in a meaningful manner.</p>

		<p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular community events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Interviewed residents confirmed they find the programme satisfactory.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living with dementia. Activities are offered at times when residents are most physically active and/or restless. This includes short walks into the secure gardens, newspaper reading, van outings, music entertainment, colouring, manicure, sing-along, jigsaw puzzles, movies, word games and dancing.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the triage RN.</p> <p>Formal care plan evaluations occur every six months following six-monthly interRAI reassessments, 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 acute infections and wounds. When necessary, unresolved problems are added to long term care plans. Interviewed residents and families/whānau confirmed being involved in evaluation of progress and any resulting changes or in multidisciplinary review meetings.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) 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>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. All the general practitioners providing services are based locally in Cambridge. The resident can keep their normal general practitioner. 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 district nurses. 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 the DHB emergency department in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and</p>	FA	<p>Policies detail how waste is to be segregated and disposed. The policy content aligns with current accepted practice. Recycling of cardboard, plastic and glass is occurring.</p> <p>Chemicals sighted were stored in designated and secure areas. Material safety data sheets detailing actions to take in the event of exposure were sighted for chemicals in use. Applicable staff have been</p>

<p>service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>provided with training on chemical safety and handling. A hazardous substance register is maintained.</p> <p>Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, and eye / face protection. Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system. Applicable staff and contractors confirmed receiving education on handling chemicals and waste as part of health and safety induction and orientation where relevant to their role.</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>PA Low</p>	<p>A current building warrant of fitness (expiry date 12 May 2020) is publicly displayed. The four facility vehicles have a current registration and warrant of fitness.</p> <p>Cambridge Resthaven applied to the Ministry of Health in late 2018 to request five beds in the secure dementia unit to be multipurpose and used either for the provision of rest home and hospital level care or all used for dementia level care, depending on service demand. The secure dementia unit was built with 20 bedrooms. Some have ensuite bathrooms. There are five bedrooms that are in a hallway on one side of the unit adjoining the rest home and hospital area. There is a door that can be programmed to be opened by swipe card at two locations in this corridor. This enables staff to secure the dementia unit with either 15 bedrooms or 20 bedrooms. The lounge and dining / kitchenette area in the dementia unit are not affected by this change. There are sufficient bathroom facilities in the dementia unit regardless of which door is being used for security. The five bedrooms are suitable for either rest home, hospital or dementia level of care residents.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. There is an appropriate and secure external area attached to the dementia unit where residents can go walking.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. Residents and family members were happy with the environment.</p> <p>Clinical equipment is calibrated. The environment is fit for purpose. The temperature of hot water is not always within an appropriate range.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes some bedrooms with ensuite bathrooms. Some ensuite bathrooms are shared between two bedrooms. Hand basins are present in each resident's bedroom or ensuite. Appropriately secured handrails are provided in the toilet / shower areas, and other equipment / accessories are available to promote residents' independence. There are separate bathroom facilities for staff and visitors to use. Privacy locks</p>

<p>toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>and signs are present on communal bathroom facilities where this aspect was reviewed.</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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All except two bedrooms provide single accommodation. One dual occupancy room is shared by a married couple and the other by residents who have been sharing a room for a long time (refer to 1.1.3). There are privacy curtains present around these bed spaces. Rooms are personalised with furnishings, photos and other personal items displayed. Residents were sighted mobilising inside and outside the facility independently and with staff support, including while using a mobility aid.</p> <p>The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</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>	<p>FA</p>	<p>All except four residents are in single occupancy rooms. There are areas throughout the facility that residents can use for activities or to meet with family and friends. This includes the lounge and dining rooms, and outside / courtyard areas. There is also a chapel / quiet room available. The residents and family members interviewed confirmed that there is enough space available for residents and support persons to use in addition to the residents' bedrooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Policies and activity lists detail how the cleaning services are to be provided. The daily cleaning services are provided by contractors including on weekends. All laundry including resident's personal clothing is sent offsite to a commercial laundry daily and washed and returned folded and packaged per resident. Processes are in place with the laundry to place microchips in each garment for the naming of long term residents' clothes on admission.</p> <p>The residents and family members interviewed confirmed the rest home and hospital is kept clean and tidy and residents' laundry is normally washed and returned in a timely manner. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with the service requirements.</p>

		<p>Chemicals are stored in designated secure cupboards or rooms which are locked. Two cleaners interviewed confirmed being provided with training on the safe handling of chemicals and had written instructions readily available on the use of products and required cleaning processes / activities.</p> <p>Instructions for managing emergency exposures to chemicals is readily available to applicable staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Security and civil defence 'flip charts' direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 17 September 2014. The GM advised no change was required to the fire evacuation plan in relation to the changes in bed use (five beds) that can now be used for either dementia level care or rest home / hospital level of care. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 13 August 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including (but not limited to) food, water, lighting, blankets, radio, walkie talkies, water purifying tablets, and other commonly used consumables. A gas BBQ was present. Emergency lighting is powered by uninterrupted power supply (UPS) batteries. There is a swimming pool on the complex which could be used for potable water. The emergency plan considers the needs of residents with dementia in an emergency.</p> <p>Call bells alert staff to residents requiring assistance. Call bells are present in bathrooms, bed spaces and some corridor areas. They alert via an audible sound and notification of the room number/location through to a centralised panel. Three call bells tested at random were fully functioning. At least one HCA in each area wears a pager. Routine calls alert on all call bell communication panels and to the staff pagers. Staff advise emergency calls are alerted throughout the entire complex and have a different alert tone. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. Internal security cameras are in use monitoring public areas and access points. Signage alerts residents and visitors that cameras are in use.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and external windows. Heating is provided by a combination of wall mounted or ceiling mounted heat panels or heat pumps. Areas were at an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. There are</p>

<p>ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>currently no residents that smoke.</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 has implemented 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. The infection control programme and manual are reviewed annually.</p> <p>The staff educator is the designated infection control coordinator (ICC), whose role and responsibilities are defined in the infection control policy. Infection control matters, including surveillance results, are reported monthly to the general manager, and tabled at the quality/risk committee meeting and discussed in staff meetings. This committee includes the general manager, clinical nurse leader, ICC and the health and safety officer.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell with an infectious condition 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 ICC has appropriate skills, knowledge and qualifications for the role. The ICC has completed external training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is obtained from the infection prevention and control team at the local DHB, the community laboratory, the GP and public health unit, as required. The ICC and the RNs have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no outbreaks of infection since the last audit.</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</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 within the past year 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 are readily available around the facility. Staff interviewed</p>

<p>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>verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education 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 ICC. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance and evaluations is maintained; records sighted. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Toolbox talks and staff meeting minutes were sighted.</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 Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The ICC reviews all reported infections, and these are documented on the infections reports by the RNs. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous month and this is reported to the general manager and all staff in staff meetings. Data is benchmarked externally within a group of similar community trust aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>Policies and procedures provide guidance on the safe use of both restraints and enablers. The facility is restraint free and staff report has been restraint free since prior to the last audit. Only enablers are noted as</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>being used in the restraint / enabler register sighted with recorded information dating back to 2013. The clinical nurse leader is the restraint coordinator. Staff interviewed could detail the difference between restraint and enablers. The approved enablers are bed rails and lap belts. Training on restraint minimisation and use of enablers is included in the staff orientation and ongoing education programme.</p> <p>On the day of audit, no residents were using restraints and ten residents had enablers in use. The use of enablers is detailed in the three applicable sampled care plans. A resident interviewed confirmed using bedrails at night at the resident's choice, and that a lap belt was not required during the day for safe mobilisation. Ongoing use of enablers is reviewed within a month of commencing and then at least every six months during care plan reviews.</p>
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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)
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	Systems are in place to ensure that most aspects of the resident’s physical environment and facilities are fit for their purpose and maintained. The testing and tagging of facility owned electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Hot water temperatures are monitored monthly on a rotating basis of some resident care areas; however, the testing schedule needs review. The hot water temperature in only one resident bedroom is being monitored in the dementia unit, and showers are not included in the hot water testing regime. The temperature in one resident room has been between 46 and 53 degrees Celsius on all three occasions tested since April 2019. The temperature of hot water in some other resident care areas is low, with a recorded temperature of between 35-42 degrees Celsius during the same period. The newly employed property and development manager (has been in the role eight days as at audit), has commenced a	The temperature of hot water is being monitored on a regular basis. The current testing plan is not sufficiently representative of the building footprint. For example, it only includes one resident’s bedroom in the dementia unit and showers are not being tested. Where temperatures are above the recommended range in one area, or consistently below the recommended range in	Ensure the hot water testing programme includes all resident care areas and the water temperature is within the required temperature range.

		<p>review of hot water systems with external trade contractors.</p> <p>Staff work to keep the environment hazard free. Residents independence is promoted. Grab rails are present in the bathrooms and corridors where this was checked.</p>	<p>other areas there has not been timely action and follow-up.</p>	<p>60 days</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.

No data to display

End of the report.