

Cambridge Life Limited - Cambridge Life

Introduction

This report records the results of a Provisional 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 Life Limited

Premises audited: Cambridge Life

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

Dates of audit: Start date: 24 September 2021 End date: 24 September 2021

Proposed changes to current services (if any): Offsite provisional audit, to assess the prospective purchaser's capability to purchase Cambridge Lifecare – added to this previous cert audit report from 7-8 July 2021.

Total beds occupied across all premises included in the audit on the first day of the audit: 44



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.

General overview of the audit

Lifecare Cambridge Limited (Lifecare) provides aged care services for up to 57 residents requiring rest home or hospital level care.

The service is privately owned and the day to day operations are managed by an onsite general manager who is supported by a clinical nurse manager. Both are suitably qualified and experienced.

This certification audit was conducted against the Health and Disability Services Standards and the provider's aged residential care contract with the district health board (DHB). The audit process included an offsite review of policies and procedures, an onsite review of residents and staff files, observations of practices and interviews with residents, their families, a general practitioner, and two visiting allied health professionals.

The previous unannounced surveillance audit in April 2021 identified seven areas requiring improvement. Progress toward addressing these was also considered during this audit. Corrective actions have been implemented and the following five areas

were verified as resolved: back up for the General Manager's role, staff orientation, evaluating the effectiveness of pro re nata medicines and performance monitoring of clinical equipment have been addressed.

The two areas related to timeliness of interRAI assessments and development of long-term care plans remain open. One new improvement is required regarding the effectiveness of the call bell system.

The Ministry of Health requested confirmation that the recommendations made by the Office of the Health and Disability Commission regarding end of life care had been implemented and were embedded in practice. Sufficient evidence of planning, communication, timeliness of hospital referral and evaluation of care was verified at this audit.

Residents and family members interviewed were satisfied with the manager, staff and the services they provide.

Provisional Audit

The Sound Care Group (SCG) have signed a sale and purchase agreement with Lifecare Cambridge Limited to purchase the aged care services being delivered at Lifecare. The anticipated settlement date is 10 November 2021. The Ministry of Health (MoH) HealthCert, have approved this provisional audit to be conducted off site using the findings (contained in this report) from Lifecare's most recent July 2021, certification audit.

Evidence to establish the preparedness and suitability of the prospective provider was derived from a telephone interview with the director of SCG, and consideration of their transition plan and other documents provided as part of the process.

There were no areas of concern identified during this off-site audit. SCG have proven competence and experience as operators of four other aged care services in New Zealand. They demonstrated readiness to take over the business and delivery of care services as soon as settlement and approval from the MoH has occurred. Waikato District Health Board are aware of the proposed change of ownership.

The business will be owned and operated by Cambridge Life Limited under the Sound Care Group and trade as Cambridge Life.

Consumer rights

On admission to Lifecare Cambridge, the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and their family members. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

The facility provides services to residents that respect the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed and reported to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

Complaints have been acknowledged, investigated and responded to. Residents and family members interviewed confirmed they are aware of the complaints process.

Organisational management

The organisation's scope philosophy, mission and values are identified in the business plan (2020-2022). Day to day care and all aspects of service delivery are competently managed by an experienced and suitably qualified general manager and clinical nurse manager.

The quality and risk management system includes internal audits, and the collection and analysis of quality improvement data such as complaints, incident/accidents, health and safety, restraint minimisation, resident and family feedback, and surveillance for resident infections. The analysis of data assists in identifying trends and leads to improvements.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. The policy and procedure set support best/safe known practice in service delivery and are kept current through regular reviews and updates from the external owner of the system.

Outcomes from quality and risk management activities are regularly shared with all staff and the business owner.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents. There is at least one registered nurse on duty at all times.

Residents and family members confirmed during interview that all their needs are met.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated electronic and hard copy files.

Continuum of service delivery

Lifecare Cambridge works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/whānau to facilitate the admission.

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

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified. Residents and whānau interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is good. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is provided by a diversional therapist and an activities co-ordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Waste and hazardous substances are well-managed. Sufficient supplies of protective equipment and clothing is stored on site and staff were observed using this appropriately. Chemicals are stored and managed safely.

There is a current building warrant of fitness. The environment meets the needs of residents and all areas inspected were clean and well maintained. Electrical and medical equipment is routinely tested. Laundry is undertaken onsite and routinely evaluated for effectiveness.

External areas are maintained as safe and accessible to all residents. There are various outside areas that provide shelter/shade which are furnished appropriately for the age group of residents.

Staff are trained in emergency procedures and use of emergency equipment and supplies. Fire evacuation procedures are regularly practised.

Residents and families were satisfied with the timeliness of staff responses.

Security is maintained. Communal and individual spaces are maintained at a comfortable temperature

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. There were two residents using restraint at the time of audit and three residents using enablers.

Staff understood that the use of enablers is voluntary and only implemented at the individual request and consent to use these.

A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and are provided regular education.

Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the Waikato District Health Board.

The programme is reviewed annually.

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, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	0	3	0	0
Criteria	0	98	0	0	3	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>Lifecare Cambridge has policies, procedures, and processes in place 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 provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent</p>

		<p>is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day-to-day care on an ongoing basis.</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>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. 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>Staff were aware of how to access the Advocacy Service.</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>	FA	<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' 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>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and compliments / concerns and complaints forms were clearly on display at the main entrance. The complaints register contains information related to four complaints received from residents or family members since the April 2021 audit. Records showed the complaints were investigated and responded to in a timely manner. Meeting minutes showed two residents have provided 'feedback' or noted a concern and these were all discussed and addressed.</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. The GM stated there have been no known complaints about the service to the DHB or HDC since the 2019 HDC investigation. Evidence that the recommendations made by the HDC in relation to end of life care planning and staff communication are implemented and embedded in practice was verified during this audit and reported on in standards 1.1.9, 1.3.3, 1.3.5 and 1.3.8.</p> <p>Residents and family members interviewed confirmed they are aware of the complaints process and had no complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>Residents and family members of residents, when 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. The Code is displayed in common areas around the facility together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>Provisional Audit</p> <p>The Sound Care Group director interviewed, demonstrated a thorough knowledge and understanding of the Code and its requirements, and described various methods for implementing and monitoring adherence to the Code in everyday practice. The group own and operate four other aged care facilities and the directors and their executive team have attended education on the rights of residents (the Code) and are diligent in ensuring their care staff uphold these rights. The director confirmed there was sufficient information available on site and that the processes already in place meet the requirements and the needs of residents.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and</p>	FA	<p>Residents and their family members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Not all residents at Cambridge Lifecare have a private room. Two rooms</p>

<p>independence.</p>		<p>are triple rooms, and four rooms are double. Residents and their families are advised prior to occupancy of the need to share a room if this is the occupancy status at the time. Efforts are made to ensure compatibility in shared rooms. Privacy in shared rooms is maximised with curtains between all beds. Several small lounging areas are located throughout the facility, enabling opportunity for privacy during family discussions. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the general practitioner (GP).</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each care plan 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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</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>There was one resident in Lifecare Cambridge at the time of audit who identified as Māori, plus one staff member. Interviews verify staff can support residents 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 to Māori residents. There is a current Māori health plan developed with input from Te Kohao Health at the Waikato District Health Board (WDHB), who also advise when needed.</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 their family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire included evaluation of how well residents' cultural needs are met, and this supported those individual needs are being met.</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. A GP also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</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, physiotherapist, wound care specialist, speech language therapists, community dieticians, services for older people, and mental health services for older persons, and education of staff. The GP 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 have access to online learning resources to support contemporary</p>

		<p>good practice.</p> <p>Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided, evidenced by an ongoing initiative aimed at a reduction in the number of falls, a commitment to improving the RNs knowledge of wound care management and products available, reducing the number of wounds and wound infections, and evidence of a reduction in the numbers of residents requiring the use of a restraint.</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>Eight residents and family members stated they were kept well informed about any changes to their own or 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 all residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>An interview with the GP verified staff contact the GP in a timely manner, and there has been no events where timeliness in contact has been of concern. Staff respond promptly to all requests. Emails plus the ISBAR format are used when contacting the GP. Information provided by staff was appropriate and relevant. A phone call to the GP is made when urgent attention is required. The GP is available by phone afterhours but is not always available to attend to the resident at that time.</p> <p>Interpreter services can be accessed via the Waikato District Health Board (WDHB) or by using the verbal translation application on a mobile phone. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p> <p>A resident who is profoundly deaf has been teaching staff sign language, which staff were observed using when communicating with the resident. A sign language sheet has been developed for staff to follow if they are not proficient in sign language. The clinical nurse manager (CNM) is also able to teach sign language.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business plan 2020-2022 is reviewed regularly and includes a mission statement, business objectives, values, strengths, weaknesses, opportunities and threats of the organisation.</p> <p>The general manager (GM) has been in the position since March 2020. This person has extensive experience in aged care as a manager and clinical nurse manager prior to being employed at Lifecare. The GM is maintaining a current practising certificate as an RN and attends at least eight hours of education related to the role.</p> <p>The GM is supported by a clinical nurse manager (CNM) who commenced the role in April 2021. The CNM has a current practicing certificate. The GM and the CNM continue to work well together providing competent leadership in clinical matters and operational oversight for all service delivery.</p> <p>Lifecare Cambridge has an Age Related Residential Care (ARRC) agreement with Waikato DHB to provide hospital and rest home level care.</p> <p>There are supplementary contracts for respite/short term care, palliative/end of life care, long-term support-chronic health conditions (LTS-CHC) , Post-Acute Care (PACC) and another DHB care package- the rest and recuperation scheme (R n R).</p> <p>The facility is certified to provide accommodation for up to 57 residents, although only 56 residents can be accommodated because a previous two bedded room is now designated as a palliative care room which contains one bed. The GM advised that the facility was certified to have up to 57 hospital level care residents as all beds were advertised as 'dual purpose'. Enquiries with HealthCERT and the DHB revealed that the bed configuration was recorded as 21 hospital level care beds and 36 beds as dual purpose (rest home or hospital). But some rooms were definitely not suitable for hospital level care, because of their size, location and lack of hand basins. An agreement was reached with the GM to designate 12 rooms as rest home only. This is discussed further in standard 1.4.4. The agreed configuration was 21 hospital beds, 24 dual purpose beds and 12 rest home beds.</p> <p>On the first day of audit there were 42 residents (nine hospital level care residents and 33 rest home). Two admissions in the afternoon increased</p>
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		<p>the hospital number to 11 which gave a total of 44 residents.</p> <p>Of these 44 residents, 33 were receiving full or partial subsidies as long term residents under the age-related residential care contract. Seven residents were private payers. Six rest home residents were on short stay respite, one of whom was aged under 65 years and funded under the DHB 'R and R contract'. One hospital resident was palliative and cared for under the end-of-life care contract and one other rest home resident was under the age of 65 under the LTS-CHC.</p> <p>The service also provides meals on wheels and a day programme, neither of these were not included in this audit.</p> <p>Provisional Audit</p> <p>The business will be operated by Sound Care Group (SCG) and will trade as Cambridge Life. The directors of SCG already own and operate four aged care facilities. A rest home with dementia care in Eltham purchased in 2017, a rest home/hospital service in Whangarei purchased in 2019, and a rest home/dementia/hospital facility in Athenree Bay of Plenty purchased in 2020, and South Care Rest Home and Hospital in Dunedin purchased in 2020. The directors and executive management team are RNs with current practising certificates and extensive experience as nurses, clinical managers and facility managers in the New Zealand aged care sector.</p> <p>The sale and purchase agreement for buying the business and care services is due to settle on 10 November 2021. The buildings and fixtures will remain the property of the existing owner with a first option for SCG to purchase the land and buildings if they choose to in the future. SCG stated that the transition period will be managed between themselves and the current owner to ensure the least amount of stress and anxiety for residents and relatives and with minimal disturbances on staff routine.</p> <p>There are no short term plans for changes in the service scope or size. SCG may consider extending the service scope to include service delivery for young people with disabilities or dementia care depending on local need and demand.</p> <p>The directors of Sound Care Group have an organisational structure and executive management team, including the director/owner, and 'roving'</p>
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		<p>general manager who supports each facility manager, a clinical manager who supports clinical managers and a clinical support manager who supports RNs and clinicians in their roles. This is further described in standard 1.2.8</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>	FA	<p>This was an area identified as requiring improvement at the previous audit. Since then arrangements have been made with an experienced facility manager to provide cover if and when the GM is absent for any length of time. A signed agreement that explained and confirmed the terms of agreement was sighted. If the CNM is absent the GM who has a current APC and maintains knowledge of all resident care would cover, with a senior RN 'acting up' for support with clinical oversight.</p> <p>Provisional Audit</p> <p>The director of SCG stated they will operate the facility/home using the same systems it has in place for their other homes. In the event of the facility manger being unavailable the roving general manager will be seconded to Cambridge Life for the period of absence.</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>	FA	<p>The quality assurance and risk management plan has a strategy with clear objectives and reflects a commitment to continuous quality improvement. The quality improvement cycle is detailed.</p> <p>Quality related data is being collected, collated and analysed to identify trends. This data includes adverse events, infections and restraint events, resident and family feedback, concerns and complaints and results from internal audits.</p> <p>A sample of meeting minutes showed this information is being regularly presented and discussed with all levels of staff via regular meetings. For example, at the weekly registered and enrolled nurse meetings, the monthly health and safety/management/quality improvement meetings (which discuss restraint and infection control matters), general staff/HCA meetings, and kitchen and housekeeping meetings. There were separate restraint approval group and resident meetings occurring at regular intervals.</p>

	<p>Current meeting minutes were readily available in the staff room, the RN/EN office and the manager's office.</p> <p>Staff confirmed this information is communicated clearly and opportunities for improvement discussed. They said they were kept reliably informed about residents, changes to policy/procedures and any other aspects of service delivery. In addition, information was being communicated with staff via time target, displayed notices and at shift handover.</p> <p>Quality and service monitoring is occurring through internal audits and the resident/relative feedback programme. Results of the most recent family survey have been collated and analysed. Feedback that required follow up was being investigated and actions taken to address the matters raised. This aspect of the previous non-conformance has been addressed. Family and resident feedback elicited from this audit was positive about the changes being implemented. The new leadership team demonstrated a 'can do' and 'just do it' approach to implementing improvements.</p> <p>The findings from the April 2021 audit related to outcomes from internal audits not being clearly understood or followed up on have now been rectified. The way the system presented information was not understood by the GM at the time. The system was presenting 100% achievement for the number of criteria assessed which the GM interpreted as 100% compliance with the audit tool, although non-conformities had been identified. There was adequate evidence that findings from internal audits was interpreted and presented accurately and improvements implemented as a result. This shortfall has been addressed and the matter is now closed.</p> <p>Lifecare policies and procedures are available on line and in hard copy. These were reviewed and found to be current, relevant to the scope and complexity of the service, reflecting accepted good practice, referenced to legislative requirements and referring to interRAI requirements. Policies and procedures are reviewed and updated at least annually or sooner when required by an external quality consultant. New / reviewed policies are printed for staff to read and sign off after reading. Staff also confirmed the policies and procedures provided appropriate guidance for service delivery.</p>
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	<p>Actual and potential risks are identified and documented. The risk / hazard register includes clinical, environment, staffing and financial risks. A risk matrix is used to rate the level of risk. The GM is responsible for health and safety (H&S) and the management of hazards with regular input from staff members of the health and safety committee. Hazards were being communicated to staff and others as appropriate, and mitigation strategies implemented for new hazards. Staff confirmed they understood and implemented documented hazard identification processes and that minutes of the H&S committee meeting were always available. All staff related accidents and incidents are discussed at the H&S meeting. There have been no staff injuries requiring notification to WorkSafe NZ this calendar year.</p> <p>Provisional Audit</p> <p>Sound Care Group intend to retain the existing quality and risk system which includes the policies and procedures already in use at Lifecare Cambridge. This system reflects the principles of continuous quality improvement (CQI), is tailored for the age care sector and moderated by the external owner of the programme. It includes regular internal audits, systems for analysis, benchmarking and reporting of quality data, such as trends in incidents/accidents, complaints, infections and restraint interventions, and providing regular opportunities for resident, family and other stakeholder feedback. The transition plan contains an annual quality plan with time framed internal audits, quality goals and other mechanisms for obtaining quality feedback.</p> <p>Interview with the Sound Care Group director revealed that the group intend to implement a uniform quality and risk system across all their facilities. This may take time to evolve.</p> <p>Sound Care Group demonstrated they have the skills, experience and knowledge to implement effective quality and risk management systems through their ownership of four other aged care facilities. The executive management team who are all registered nurses, understand best known practice in aged care, contractual requirements, current regulations, and legislation including health and safety legislation.</p> <p>The documented transition plain included a detailed 'strengths, weaknesses, opportunities and threats' (SWOT) analysis which identifies known and potential risks. All risks have associated mitigation</p>
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		<p>strategies.</p> <p>Quality goals related to the purchase of Cambridge Life are: 1) a smooth transition; 2) retaining the current staff; and 3) adding to the quality of services provided.</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>Unplanned or untoward events including accidents and incidents were now being entered into the electronic system by the CNM, from paper reports presented by staff as they occurred. This facilitates immediate review by the CNM who ensures that reporting is accurate, including the degree of risk, that notifications have occurred and preventative measures taken to reduce the likelihood of recurrence. The CNM is taking responsibility for monitoring the effectiveness of any corrective actions implemented as a result of the incident and closing out the event. The registered nurse on duty is responsible for initial assessment of the resident and developing any care plans if injury had occurred and required a plan.</p> <p>A review of the electronic register for incidents from February to June 2021 revealed that the number of incidents was steadily declining. For example, there were 45 reported events in February, 46 in March, 40 in April, and 16 in May. These figures included staff events, near misses and other non-resident incidents. A sample of (10) June events included residents' behaviour of concern, falls, (with and without injuries) skin tears, bruises/grazes, staff injury, resident wandering and a medicine error. All contained sufficient detail and included recordings of neurological observations for residents whose falls had not been witnessed and/or involved impact to the head. This was a non-conformity identified at the previous audit which has been addressed.</p> <p>Staff interviewed demonstrated a good understanding of the type of events they are required to report promptly to the RN on duty or the GM, and how to record the incident.</p> <p>The family members and GP interviewed said they were informed in a timely manner of any accidents and incidents and actions taken. They had no concerns about under or non-reporting of events.</p> <p>The electronic system provides analysis and trending of reported events</p>

		<p>and enables monthly comparison to monitor themes and trends over time. Meeting minutes showed that analysis and learnings from incidents were being shared and discussed with staff at their meetings. This was followed up with pictorial graphs displayed in the staff room that highlighted month by month trends for all categories of incidents including the locations and the times that events occurred.</p> <p>The GM is aware of essential notification responsibilities and stated there had been no Section 31 notifications to the DHB or HealthCERT/MoH since the previous audit.</p> <p>Provisional Audit</p> <p>Interview with the director of SCG confirmed a sound knowledge and understanding about the requirements for adverse event reporting including Section 31 notifications. The transition plan described a thorough analysis of all potential and actual risks with the current service. There are no known events requiring notification to relevant authorities at this time.</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>FA</p>	<p>Policies and procedures relating to human resource management are based on relevant legislation and good employment practices. The sample of staff files contained evidence of robust recruitment. For example, completed application forms, notes from referee checks, police vetting and interviews conducted. Employment agreements, and the code of conduct documents were signed and job descriptions detailed different role responsibilities. Copies of the most current practising certificates for employed and contracted registered health professionals were sighted.</p> <p>Staff are provided with an orientation programme applicable to their role. This was an area requiring improvement at the previous audit. Documented evidence and interviews showed that all staff, including those who were long term employed, have completed a comprehensive orientation programme including competency assessments and questionnaires.</p> <p>There is an ongoing staff training programme and records of attendance were being maintained. This was also an area requiring improvement. A</p>

		<p>staff training and competency register was sighted, which contains dates of education, first aid, role specific competencies and evidence of completed performance appraisals for all staff. Both shortfalls from the last audit had been effectively addressed.</p> <p>Of the 25 HCA's currently employed (including one casual) eight have achieved Level 4 of the National certificate in Health and Wellbeing as required in the ARC contract. Three had achieved level 3, two had achieved level 2 and eight were at level one. Four new staff are preparing to commence the education.</p> <p>At the time of the audit five permanent and two casual RNs were employed, plus the GM and CNM. Of these, one RN and the GM were interRAI trained and maintaining their competencies. The GM advised another RN with interRAI competency was due to commence employment in July. Due to the lack of trained staff, interRAI assessments were not always being completed within three weeks of admission or at times, reviewed every six months. This area of non-compliance is ongoing (refer to criterion 1.3.3.3).</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery and this includes resident acuity and staff skill mix. Registered nurse cover is provided 24 hours, seven days a week. The GM and CNM work full time Monday to Friday and are on call after hours.</p> <p>Five RNs are currently employed working regular shifts and two RNs work casual shifts. Three enrolled nurses work regular shifts in the rest home area with another EN available for casual shifts.</p> <p>Review of the rosters, and interview with staff verified that there is an RN and EN and six HCAs on each morning shift, (the RN and three HCAs allocated to hospital residents and the EN and three HCAs in the rest home) In addition to this the CNM and GM who have current nursing certificates, are on the floor Monday to Friday.</p> <p>One RN and an EN and four HCAs are rostered on for the afternoon</p>

		<p>shift and one RN and two HCAs are rostered on each night.</p> <p>A physiotherapy assistant provides 1:1 exercises with residents three days a week to carry out rehabilitative routines prescribed by the physiotherapist who visits each week. The physio assistant also cooks in the kitchen twice a week.</p> <p>The activities coordinator works full-time hours Monday to Friday with support and input from by a registered diversional therapist three days a week who also works shifts as an HCA. This team have successfully implemented a programme that attends to all residents' recreational needs.</p> <p>There was a suitable number of laundry, cleaning, maintenance, administration, and reception staff employed for sufficient hours each week. The maintenance person is on site five days a week for five hours a day.</p> <p>The laundry is staffed seven days a week from 7am to 3pm and then again from 3pm to 5.30 pm (two shifts). A sufficient number of cleaners are employed to carry out cleaning tasks seven days a week which provides general cleaning every day including toilet and shower and a deep clean of every resident's room at least every six weeks. All areas of the facility were observed to be spotless during the audit and feedback from residents and family about cleanliness was positive.</p> <p>Two new and very experienced cooks have been employed since the previous audit. They work with kitchen hands to provide food services seven days a week from 5.30 am to 6.30 pm.</p> <p>One more guest services/hospitality person has been appointed to alleviate demands on HCAs. These two staff provide tea trolley service, meal time assistance, bed making and linen changes and other general tasks.</p> <p>The previous month's rosters showed that all duties were covered to provide safe staffing. Staff advised the roster is released in a timely manner and any subsequent changes in shifts negotiated. There were enough casual and employed staff to cover absences and use of agency staff continues as infrequent. Staff advised their availability for additional shifts by writing on the roster.</p>
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	<p>Residents and families were satisfied with the staffing and services. An allied health professional commented there were times they didn't encounter any care staff member during their visits but could always find someone to report to if needed.</p> <p>Observations during this audit confirmed adequate staff cover is provided, with residents ready for any planned outings, and assistance provided with meals, and fluids where this is required.</p> <p>Provisional Audit.</p> <p>The transition plan and interview with the director of the South Care Group stated an intention to offer each current staff member an employment agreement. They propose no significant changes to key personnel and described the following organisational structure with clear job descriptions for each position:</p> <p>The Director/Owner will be in-charge of the facility's business matters.</p> <p>The General Manager of Sound Care Group will support the Facility Manager of Cambridge Life with the facility's operation. These managers will share 24 hours a day, seven days a week (24/7) on-call work for urgent non-clinical issues.</p> <p>The overall Clinical Manager of Sound Care Group will support the Clinical Manager of Cambridge Life in ensuring continuity and improvement of quality nursing service. These managers will share 24/7 on-call work for urgent clinical issues.</p> <p>The Clinical Support Nurse Manager (CSM) of Sound Care Group will support the nurses of the facility. The CSM will share the 24/7 on-call work for urgent clinical issues.</p> <p>The Human Resource Manager of Sound Care Group will manage everything related to Human Resource – recruitment, staff files management, appraisal etc.</p> <p>The onsite Facility Manager and Clinical Manager will ensure that registered nurses are supported in their roles and day to day practice.</p> <p>Registered nurses will ensure resident's health, safety, and overall well-being are of highest priority. RN's will ensure that all work delegated to the healthcare assistants are followed through.</p>
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		<p>Healthcare assistants will remain as the first point of contact of care and will liaise with the on duty RNs and nurse lead to share all necessary information regarding resident's care.</p> <p>A diversional therapist (DT) will be hired to ensure that activity planning for residents is individualised and appropriate.</p> <p>An activity person will work together with the DT to ensure that the activity plan is adhered to, and that residents' social growth is given a great deal of importance.</p> <p>The current maintenance person will manage and action maintenance issues.</p> <p>The cook(s) with the help of the kitchen staff will ensure high standards of the current food service delivery to both residents on-site and meals on wheels clients.</p> <p>Cleaners will ensure the cleanliness and order of the facility.</p> <p>Laundry personnel will ensure a good standard of laundry services is maintained.</p> <p>The administrator will maintain organisation of the records of the facility.</p> <p>The prospective provider (SCG) has a documented and practicable policy regarding staffing. This describes meeting contractual obligations and allocating sufficient staff depending on the acuity of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. 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. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>The organisation is in the process of changing from hard copy resident notes to electronic ones.</p> <p>Archived records are held securely on site and are readily retrievable</p>

		<p>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>Electronic medication and resident records are stored in a secure portal.</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 are admitted to Lifecare Cambridge 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 meet with the general manager (GM) or the clinical nurse manager (CNM). They are also provided with written information about the service and the admission process.</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.</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 WDHB '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. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>The medication management policy is current and identifies all aspects</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN 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. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's 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 is consistently recorded on the electronic medicine chart.</p> <p>There were two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN, CNM and GM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used at Lifecare Cambridge. Standing orders meet standing order guidelines.</p>
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<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 cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in June 2019. The present menu is with the dietitian being reviewed, and this is verified by email.</p> <p>An up-to-date food control plan is in place and registered with the Waipu District Council. The verification audit found two areas requiring corrective action. These have been addressed. The plan was verified for 18 months and is due to expire in June 2022.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</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</p>

		<p>reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. 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>	<p>FA</p>	<p>On admission residents of Lifecare Cambridge are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, and depression scale to identify any deficits and to inform initial care planning. Except for those files referred to in criterion 1.3.3.3, residents are assessed using the interRAI assessment tool to inform long term care planning, within three weeks of admission.</p> <p>Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. Interviews, documentation, and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>As referred to in criterion 1.3.3.3, not all residents have current interRAI assessments completed by two interRAI assessors on site.</p> <p>All residents who fall, have a post fall assessment by an RN. Neurological observations within the required timeframes are undertaken for any unobserved fall or if the resident has banged their head. Regular weighs, blood pressure and blood sugar monitoring (where required) is recorded and evidenced on Medimap. Wound care assessment is sighted in residents with wounds, with photos of the wound used as part of the assessment/evaluation process. All pro re nata (PRN) medications administered are assessed for their effectiveness and this is recorded on the electronic medication record. All residents with pain have ongoing pain assessments and monitoring of the pain management regime. The resident receiving end of life care has a plan in place to ensure the resident remains comfortable. Ongoing assessment of the care provided</p>

		was observed.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Plans reviewed did not consistently reflect the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Absence of an interRAI assessment or an updated interRAI resulted in the needs (that would have been identified by the interRAI assessments) not being reflected in the care plans reviewed. Care plan documentation did not consistently evidence service integration with progress notes, activities note and medical and allied health professional's notations. This is an area requiring attention. This was only reflected in the documentation, not through the care being provided to the resident.</p> <p>Any change in care required was documented in the progress notes and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care provided to the resident</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>Documentation, observations, and interviews verified the provision of care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in handovers and verbal orders rather than the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. An interview with a resident receiving end of life care, expressed a high degree of satisfaction with the care being provided. An interview with a family member who's relative displayed a degree of changing behaviour, felt the resident's assessment and placement in Lifecare Cambridge where it was not secure, did not expose the resident to risk.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a diversional therapist, who works two days and an activities coordinator.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents, this however is not documented. The resident's activity needs are not evaluated regularly and as part of the formal care plan review every six months (refer criterion 1.3.3.3 and 1.3.5.2).</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, visiting entertainers, quiz sessions, bingo, crafts, outings, and daily news updates. The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the activities provided. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN, CNM and GM</p> <p>As per that referred to criterion 1.3.3.3 and 1.3.5.2, in the seven files reviewed formal care plan reviews are not documented. Where progress is different from expected, the service responds by initiating changes to the care being provided. Examples were sighted of short-term care plans being consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. The GP has access when offsite to the electronic medication management system, and can access recordings, weights, wound photos, PRN usage, and medication usage, to enable good oversight of</p>

		<p>any resident concerns, in consultation with contact by the facility.</p> <p>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 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>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP/RN/CNM or GM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the GM or the GP. The resident and the family 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>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There were sufficient stored supplies and availability of protective clothing and equipment and staff were observed using this.</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>	FA	<p>A current building warrant of fitness expiry date 17 June 2022 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment occurred in May 2021 and</p>

		<p>calibration of bio medical equipment occurred in April as confirmed in documentation reviewed and interview with the maintenance person. Documented evidence of regular checks by external suppliers and staff of all other equipment including hoists, was sighted. The previous non-conformance about equipment checks is now rectified and the matter is closed.</p> <p>The maintenance person is on site five days a week for five hours a day maintaining equipment, ensuring the environment is hazard free and that residents are kept safe.</p> <p>Residents have easy access to a number of outside areas which are suitably furnished.</p> <p>Staff confirmed that requests for repairs or maintenance are actioned in a timely way. Residents and family members were happy with the environment.</p> <p>Provisional Audit</p> <p>Telephone interview and review of documents submitted confirmed that SCG have no short-term plans to change the building footprint. The directors are knowledgeable about NZ building requirements including essential emergency and security systems and what constitutes an appropriate, accessible and fit for purpose environment for older frail persons.</p> <p>The prospective provider (SCG) is aware of the requirement to rectify the call bell system which was identified at the July 2021 certification audit.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Twenty two bedrooms have full ensuite bathrooms. All other bedrooms are in close proximity to at least one toilet and a shower/bathroom.</p> <p>Temperature monitoring of all hot water outlets occurs each month. The records of this showed that where residents have access to hot water, the temperatures are kept below 45 degrees Celsius. Temperatures in utility areas such as the kitchen and laundry, were being maintained at</p>

		<p>around 60 degrees.</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>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>A reconfiguration for use of beds was assessed during this audit. The facility was advertising that all 57 beds were for dual purpose use, although a number of rooms were obviously not suited to accommodate hospital level care residents. These had single doors, were too small to easily allow staff manoeuvres or use of lifting equipment, were located too far away to provide regular checks or sighting of residents and did not have hand basins. At the time MoH had the configuration listed as 21 hospital beds and 36 dual purpose (rest home or hospital). Agreement was reached to designate 12 rooms as rest home only. The GM has submitted an application to HealthCERT, MoH to reduce the number of dual purpose beds from 36 to 24. This provides 21 hospital designated rooms, 24 dual purpose and 13 rest home. For the record, the rooms identified as suitable for rest home use only were R1, 2, 3, 4, 5, 8 and 9 in the centre wing and rooms E1, 2, 3, 6 and 7 in the East wing.</p> <p>All dual purpose and rest home bedrooms provide single accommodation, six hospital rooms are shared. Two rooms have three beds and four rooms have two beds. These shared rooms have adequate curtaining to provide visual privacy. Residents and /or their families are advised about this prior to admission and there was evidence that consent to share had been obtained.</p> <p>Rooms were observed to be personalised according to the resident's preferences with furnishings, photos and other items displayed.</p> <p>There are sufficient spaces to store mobility aids, wheel chairs and mobility scooters.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate,</p>	FA	<p>There are suitably sized dining and lounge areas in both the hospital and rest home wing which are within close proximity for residents and staff.</p> <p>Hospital residents who wanted to join others at meal times were</p>

<p>and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>observed to be eating at tables in the dining room. The rest home dining area has been relocated to an area which affords more space and a more relaxed eating experience. Those residents who wished to eat in their rooms were provided tray service. Activities were observed to be occurring in the large hospital lounge and in rest home areas. .</p> <p>Residents can access areas for privacy, if required. Furniture throughout the facility was deemed appropriate to for residents' needs.</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>Laundry is undertaken on site in a dedicated laundry and by family members if requested. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. They reported encountering incidents of soiled linen which were being reported via the incident system. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>All cleaning and laundry staff have attended safe chemical handling training (01 July 2021) and other relevant training such as emergency preparedness, restraint, and infection prevention and control. This was confirmed in interviews with staff and sighted in training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes were being monitored through regular internal audits and resident/family feedback. There was documented evidence of actions being taken to rectify any gaps or problems in the delivery of these services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was reviewed and approved by the New Zealand Fire Service in 2015 after the new wing was built. A trial evacuation takes place six-monthly with a copy sent to the Fire and Emergency Services New Zealand (FENZ), the most recent</p>

		<p>being on 19 May 2021.</p> <p>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 or power outage, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for a maximum capacity 57 residents plus staff. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. There is a large capacity water storage tank on site which is gravity fed and emergency lighting is regularly tested.</p> <p>Call bells cannot be heard in all areas of the facility. This means that if an emergency call is activated not all staff will be alerted. There have been call bell failures in the past at this facility. The GM has equipped all staff with walkie talkies to mitigate this risk but a long term solution is required. Refer corrective action in criterion 1.4.7.5</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There have been no reported security breaches nor were any concerns expressed about the security of the building or risks to staff and resident welfare.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Bedrooms are provided with sufficient natural light via opening external windows there is plenty of safe access points to outside gardens via doors in common areas. Heating is provided by a variety of electrical heaters in residents' rooms and in the communal areas. It was noted that the 'Goldair' wall mounted heaters in the hospital rooms were very noisy when first switched on. These would sometimes settle down and if not had to be switched off. As residents were not perturbed by this the matter was not pursued.</p> <p>Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external advisory company. The infection control programme and manual are reviewed annually.</p> <p>The GM with input from the CNM is the interim infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the GM, and tabled at the bi-monthly staff meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked nationally with other aged care facilities.</p> <p>Signage at the main entrance 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 related 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 GM/relieving ICC has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken online training in infection prevention and control as verified in training records sighted. Well-established local networks with the infection control team at the WDHB. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The GM/ICC and CNM confirmed the availability of resources to support the programme and any outbreak of an infection.</p> <p>All residents and staff at Lifecare Cambridge who have consented to the Covid-19 vaccination have been vaccinated.</p> <p>The external advisory company also provides a Covid-19 pandemic plan in consultation with the Ministry of Health (MOH). This guides Lifecare Cambridge on actions required during changing alert levels.</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 IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are 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>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, online learning hubs and the GM. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in skin infections.</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 programme.</p>	<p>FA</p>	<p>Surveillance of infections at Lifecare Cambridge is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p>

		<p>The ICC/GM and CNM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via printouts, staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>A good supply of personal protective equipment is available. Lifecare Cambridge has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. An RN is the nominated restraint coordinator with the CNM providing support and oversight for enabler and restraint management in the facility. The restraint coordinator was unavailable to be interviewed, and the CMN demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of audit, three residents were using bed rails as restraints and two residents were using bedrails voluntarily at their request as enablers. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<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</p>	<p>FA</p>	<p>The restraint approval group, comprises the RN/Restraint coordinator, the CNM, GM, activities coordinator, physiotherapy assistant and the residents GP for final sign off. Members of the group interviewed confirmed they are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews that</p>

<p>providers and others.</p>		<p>there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. An RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The CNM interviewed (who was the interim restraint coordinator) described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the CNM and other staff described how alternatives to restraints are discussed with staff and family members (e.g., the use of sensor mats, low beds and fall out mattresses.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff training records showed that education and updates about restraint</p>

		<p>minimisation has occurred this year. New staff are oriented to the organisation's policy and procedures and other related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed every three months and evaluated during six monthly care plan and interRAI reviews. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint committee undertakes an annual quality review of all restraint use which includes all the requirements of this Standard. The most recent review occurred in September 2020. Individual use of restraint use is reported to monthly H&S/ quality and staff meetings.</p> <p>Minutes of the annual restraint quality review meeting confirmed that the review included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the CNM confirmed that the use of restraint has been reduced by one (from four restraints to three) since the previous April 2021 audit.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>A review of the seven of 11 files which required compliance with timeframes around interRAI assessments, activity plan and long-term care plan reviews, found three residents had no interRAI assessment completed since admission (one resident admitted in May 2020, one in April 2021, and one in March 2021). One of these had no long-term care plan in place within three weeks of admission, two had a long-term care plan in place despite not having an interRAI assessment. Of these seven files reviewed five of the long-term care plans had not been updated in the past six months. The activity plans in all seven files had no evidence of a review every six months.</p>	<p>Several InterRAI assessments, activity plans and review of long-term care plans have not been carried out within the required timeframes</p>	<p>Provide evidence the interRAI assessments are completed within three weeks of admission and reviewed every six months or as the residents needs change.</p> <p>Provide evidence the long-term care plans and activity plans are reviewed every six months or as the residents needs change.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required</p>	<p>PA</p> <p>Moderate</p>	<p>Of the 11 files reviewed, seven of these required long term care plans in place that described the required support needed to meet the resident's</p>	<p>Care plans do not always describe the required support or interventions</p>	<p>Provide evidence care plans describe the required support the</p>

<p>support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>desired outcomes. Of these seven files, one had an up-to-date long term care plan, one had no long term care plan in place, and five long term plans had not been reviewed in the last six months. Plans not in place, or changes in management was not documented/updated around behaviour management, management of a resident's breathlessness, medication updates, management of anxiety, management processes for a resident being non-compliant with the required nursing interventions, risk management strategies and management strategies for a specific infection a resident has. This was only a documentation issue. The care being provided to the resident, met the residents required needs.</p>	<p>needed to achieve the resident's desired outcomes.</p>	<p>resident requires to meet their desired outcomes.</p> <p>90 days</p>
<p>Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Moderate</p>	<p>Staff advised that call bell alerts cannot be heard in all areas of the building, if an emergency call is activated not all staff would know to respond. The current call bell system is old and parts are no longer available to repair faults. Failure in call bells has been an ongoing problem, as evidenced from historical complaints, identified at the March 2018 audit and regular documented requests for repairs and maintenance. The GM has mitigated this risk by ensuring all staff on duty carry walkie talkies. These were observed to be in regular use between staff.</p>	<p>Call bell alerts cannot be heard from all areas in the building. If an emergency activation occurs not all staff would hear this.</p>	<p>Ensure there is a functional and reliable call system available for residents and staff to summon assistance.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.