

Kumeu Village Aged Care Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Kumeu Village Aged Care Limited	
Premises audited:	Kumeu Village	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 2 December 2015	End date: 3 December 2015
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	79	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kumeu Village Aged Care Ltd (kumeu Village) provides hospital geriatric services, rest home care and dementia services (memory loss services) for up to 82 residents. On the day of this audit there were 79 residents. The service is also seeking approval to provide a hospital medical service. This was reviewed as part of this audit. Kumeu Village has been in operation for nine months. The organisation has introduced the Eden Alternative across all services and this is now well embedded.

The certification audit against the Health and Disability Sector Standards and the services contract with the district health board, included review of residents and staff files and organisation documentation, observation and interviews with residents, families, staff, managers and a general practitioner who provides services to the facility.

Kumeu Village has attained four areas of continuous improvement related to 1.2.1.1 Governance, service provision standards in section 1.3.7.1 planned activities and nutrition, safe food and fluid management 1.3.13.1 and safe environment 1.4.2.4. There are four areas identified requiring improvement. These related to consumer information, assessment process and restraint minimisation and safe practice.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

Staff demonstrate good knowledge and practice of respecting residents' rights in their day to day interactions. Staff have received education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families interviewed reported high satisfaction on how staff work in a calm and caring manner and respect each resident. The residents have developed and implemented through the resident council their own 'Residents Rights Charter' which is displayed in all areas of the service.

There is one resident who identifies as Maori at the time of the audit. The service providers report there is no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from residents and/or the residents' enduring power of attorney (EPOA). Processes are in place for advance care planning, and as medically indicated, resuscitation directives are recorded.

The organisation provides services that reflect current good practice. This is evidenced in the guidelines for care of residents who require rest home, hospital and dementia care services. The care partners have completed national unit standards for memory loss (dementia care). Evidence based practice is observed, promoting and encouraging good practice. There is regular in-service education and staff access external education that is focused on aged care and best practice.

Linkage with family and the community is encouraged and maintained.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
---	--	---

Services are planned, coordinated, and are appropriate to the needs of the residents. An owner/manager and team of four managers are responsible for the overall day-to-day operations of the facility. Strategic goals are documented for the service.

Quality and risk management processes are maintained. Corrective action plans are implemented where opportunities for improvement are identified. A health and safety programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff that is specific to their role. On-going education and training for staff is maintained.

Consumer information is managed in ways that meets the requirements of the Health Records Standard except for one area of improvement required in relation to ensuring consumer records are secure and not in public view. Archived or obsolete residents' records are being stored safely and securely.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

Continuum of service delivery

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

The services provided are clearly and accurately identified in the pre-admission information. The service has policies and processes related to entry into the service.

Residents have an initial nursing assessment and care plan developed by the registered nurses when admitted to the service. A comprehensive interRAI assessment system is currently being implemented. The service meets the required timeframes for the development of the long term care plan. When there are changes in the resident's needs, a short term care plan is implemented to reflect this. The care plan evaluations are conducted six monthly on all aspects of the care plan.

Residents are reviewed by the GP on admission to the service and at least one to three monthly, or more frequently to respond to any changing needs. The provision of services is provided to meet the individual needs of the residents. A team approach to care ensures continuity of services. Referrals to other health and disability services is planned and coordinated as required based on the individual needs of the resident. The families interviewed reported that interventions are consistently implemented and that the service manages the resident's care needs.

A safe medicine administration system is observed at the time of the audit. The service has documented evidence that staff responsible for medication management are assessed as competent to do so.

The service has planned and spontaneous activities as part of the Eden Alternative which is well embedded, with the attainment of five of ten Eden initiatives. The memory loss house activities are planned across the 24 hour period and resources are readily available. Each resident has their own elder lifestyle care plan completed by the diversional therapist. Feedback is very positive from residents and family.

The food service is managed effectively with dietitian input. The menus are documented and displayed daily. The tables in the dining room are decorated in a homely fashion. Individual dietary needs are addressed with choices provided. Special diets can be arranged. Meals are provided at appropriate times of the day with some flexibility to meet lifestyle needs.

The service has gained two ratings beyond the required full attainment (continuous improvement) for the activities programme and food services provided.

Safe and appropriate environment

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

Kumeu Village has a current code of compliance. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been tested and tagged by an authorised technician.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There are designated laundry and cleaners' rooms.

The service has implemented policies and procedures for civil defence and other emergencies with a generator on site. Regular fire drills are conducted and are scheduled six-monthly at a minimum. Residents were observed to have access in their rooms to a call bell.

External garden areas are available with suitable pathways, seating and shade provided. The dementia unit is secure with easy access to a secure outdoor area.

This audit has assessed rooms in the hospital as suitable for hospital level care under the medical contract.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

There is a restraint policy that includes comprehensive restraint procedures. The service currently has three residents assessed as using a restraint and eight residents using an enabler. Staff receive training on the principles of restraint minimisation and managing challenging behaviour. Improvements are required around environmental restraint and monitoring the use of restraint.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
---	--	--

The infection prevention and control management system is appropriate for the complexity of the service. The programme is implemented and reduces risk of infections to residents, staff, and family/whanau and visitors. The policies and procedures reflect

current good practice. Relevant education is provided for staff, and when appropriate, the residents. The infection control coordinator completes a monthly surveillance programme where infections data is collated, analysed and trended with previous data. Where any trends are identified actions are implemented to reduce infections.

The infection surveillance results are reported at the staff meetings. An infection control service provides education and benchmarking occurs with other like services which are aged care related.

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	3	43	0	3	1	0	0
Criteria	4	93	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The consumer rights policy is documented and implemented. The policy describes each individual consumer rights that meets the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers` Rights (the Code). The service policy states the Code is displayed and available to all residents, and monitored to ensure the rights of residents are respected. New residents and family/representatives are provided with a copy of the Code on admission. The Code is displayed throughout all service areas of the facility.</p> <p>Staff receive training on the Code as part of the orientation programme at commencement of employment and this is ongoing. The Code is available in English and Maori. The Code in other languages is available from the HDC office as required. The pamphlets also are available in different languages and DVDs can be accessed as required.</p> <p>Management and clinical staff interviewed demonstrated knowledge and understanding of the Code and its implementation in their day to day practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are</p>	FA	<p>Written consent processes and advance directives are fully described in policy. The policy sighted relates to informed choice and consent and this information is compliant with the Code requirements. The organisation has specific advance directive documentation which identifies residents advance</p>

<p>provided with the information they need to make informed choices and give informed consent.</p>		<p>directives prior to admission and other documentation which identifies resident and/or family/whanau involvement in the process.</p> <p>The staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Residents interviewed confirmed they have been made aware of and understand the informed consent processes and that appropriate information has been provided.</p> <p>A multipurpose informed consent form is utilised by the service provider and a copy was retained in each resident's record reviewed. Forms were signed and dated appropriately. The admission agreements sighted and filed securely in the main administration office, were signed and dated by the resident and/or representative.</p> <p>The GP interviewed understands the obligations and legislative requirement to ensure competency of residents as required for advance directives and reviews are undertaken six monthly. Reviews of health status are documented on the appropriate form available and retained in the individual resident's record.</p> <p>Registered nurses interviewed reported they received orientation/induction in the principles and practice of informed consent as part of the Code of Rights and could evidence an understanding of the Code.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>The advocacy policy documented ensures that all residents receiving care within this service have appropriate access to independent advice and support including access to a cultural and spiritual advocate whenever required. Advocacy information is made available for residents and potential residents and is displayed throughout the retirement home.</p> <p>The registered nurses interviewed are aware of how to access advocacy details if required for a resident. Pamphlets are available and the contact numbers for the Nationwide Health and Disability Advocacy Service is documented on the reverse of the pamphlet and on the reverse of the Code brochure.</p> <p>Relevant education for staff is conducted as part of the in-service education programme, as confirmed by staff interviewed.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain</p>	<p>FA</p>	<p>There are no set visiting hours and family/whanau are welcome to visit. The families interviewed confirm unrestricted visiting hours and this is appreciated. Links with family/whanau are encouraged. Residents are supported and encouraged to access community services independently, with visitors/family or as part of the planned activities programme.</p>

links with their family/whānau and their community.		The activities programme sighted verifies outings are organised weekly into the community on a regular basis. The service has a van with a valid registration and warrant of fitness which was sighted. The designated van drivers' licences were verified for those staff members who transport residents.
<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 procedure is provided to residents and relatives at entry to the service. Access to complaints forms and a suggestions box are located at reception. Complaints forms include contact details for the Health and Disability Advocacy Service.</p> <p>A record of all complaints received is maintained by the owner/manager using a complaints register. Documentation including follow up letters and resolution demonstrates that complaints are well-managed. All lodged complaints were resolved. This included one complaint lodged with the Health and Disability Commissioner and one complaint lodged with the Waitemata DHB whereby neither complaint was substantiated.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Policy and procedures identify that a discussion and clarification about the Code is undertaken as part of the admission process. The policy is in place to guide staff. The residents' rights are discussed with the resident and family/whanau on admission. The Code is displayed throughout the facility. The family members interviewed reported they have been provided with information on the Code on admission, the information is provided in the information package, information brochure and the service agreements sighted. Residents interviewed clearly understood the Code. There are residents council members and residents have developed their own 'Residents' Rights Charter' and this is displayed on all notice boards throughout the home.</p> <p>An interpreter policy is available to guide staff as are interpreter services when required. Contact details are accessible for staff.</p> <p>Interviews with family members and residents who had insight into their care, expressed high satisfaction with service delivery and stated that their rights were upheld at all times.</p> <p>Choices are available for residents and residents meetings are held on a regular basis. The residents council members meet more frequently and minutes of all meetings are maintained. The list of members on the resident council is displayed on the notice boards in all service areas. The auditors were welcomed by two representative resident council members who also attended the opening meeting.</p>

		The Nationwide Health and Disability Advocacy Service brochures are accessible. The contact numbers are on the reverse of the Health and Disability Consumers` Rights brochure. Advocacy service information is included in policy to guide staff.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Policy identifies that staff must uphold all aspects of the Code. Guidance for staff is clearly shown in policies. The privacy policy and abuse and neglect policy are developed and implemented. The abuse and neglect policy covers varying types of abuse and identifies expected staff responses should any abuse occur. The staff interviewed (registered nurses and care partners), have a good understanding of abuse and neglect and know who they should report to, if necessary. The manager is the Privacy Officer for the organisation.</p> <p>All residents` rooms are currently used as single rooms. There are no couples sharing a room at the time of the audit or shared rooms in use. Rooms are well designed to accommodate residents on a medical services agreement. There is adequate space for equipment and resources as required.</p> <p>The residents` and families interviewed reported that they were always treated with the utmost respect, dignity and privacy was maintained by all staff. The service strives to make a difference in the way the staff deliver care to residents while maintaining independence and the wishes of each resident. Privacy and maintaining independence was promoted at all times.</p> <p>The service acknowledges and recognises in the organisation`s quality strategic plan a commitment to mutual respect, dignity and consideration of individual needs to maintain health and well-being. The Eden Alternative has been adopted for the service.</p> <p>The general practitioner (GP) interviewed expressed no concerns with abuse, neglect or culturally unsafe practice.</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>	FA	<p>The Maori Health Strategic Plan/Guidelines which includes a Cultural Safety policy recognising Maori values and beliefs. The holistic framework of Te Whare Tapa Wha is recognised as being central to the residents` well-being. Policy states the organisation will ensure that the cultural values and beliefs of residents, their whanau and staff are respected, recognising the Treaty of Waitangi in day-to-day practices. There are no known barriers that exist for Maori residents to access services. Rooms are blessed as required.</p> <p>There is one Maori resident who was not able to be interviewed. The care partners interviewed demonstrated a good understanding of services that would need to be provided for Maori residents to meet identified needs and the importance of whanau. The staff education plan includes the principals of the Treaty of Waitangi and pukenga (skills) in understanding of communication during service</p>

		delivery.
<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>	FA	<p>Policy identifies that resident and family/whanau are included in all care planning to ensure values and beliefs are recognised and are met by the service. The service policy recognises that every individual is inherently influenced by the cultural environment with which they relate and that influence remains with the individual despite any change in living environment.</p> <p>The clinical nurse manager interviewed explained that the registered nurses when developing the initial and long term care plans, ensured residents` cultures values and beliefs are recognised. The registered nurses ensure that any cultural needs are identified on admission and that these are communicated to the care partners who provide the majority of personal care to residents. The registered nurses reported they have received training in cultural awareness.</p> <p>Residents are provided with support required to practice their beliefs in a manner that they have identified as important to them.</p> <p>The cultural values and beliefs along with the objectives of the Eden Philosophy are actively integrated into daily life as reflected in their respective care plans sighted.</p> <p>Cultural and spiritual advisors are available through local interdenominational services and/or through the Waitemata District Health Board (WDHB).</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff files reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries and house rules. Staff interviewed both (clinical and non-clinical) ensure they abide by these rules as part of the employment agreement and human resources management protocol.</p> <p>The discrimination policy reviewed has clear definitions of discrimination, coercion, harassment, sexual, financial and/or other exploitation to meet the requirements of this standard.</p> <p>The staff code of conduct sighted has objectives in place to be upheld for residents. The family and residents interviewed reported they are pleased with the care provided. The clinical nurse manager, quality assurance (RN) manager and all registered nurses have completed the professional boundaries workshop which is a requirement for the New Zealand Nursing Council.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Policies and procedures reviewed are reflective of evidence based practice and have been developed and implemented for the service. Some examples of good practice observed includes the standard of record management maintained for both staff and residents' records, the comprehensive assessment process, subsequent care plan development and implementation for each resident and the care plan review system which is changing to the interRAI system as more registered nurses are able to complete the required training.</p> <p>Clinical audits, such as the six week post admission audit, and medication systems audits completed by the pharmacist are evidenced.</p> <p>The implementation of the quality management strategies and the Eden Alternative initiatives are already reflected across the organisation in just nine months of operation. The internal quality system and internal audits already performed are fed back to the staff at the staff meetings (minutes sighted). There is a registered nurses communication book located in the pharmacy/treatment room and staff interviewed stated this works effectively. Appointments for individual residents, staff messages and medication changes are clearly documented.</p> <p>The infection control programme is managed by the clinical nurse manger and benchmarked against other aged care related services. The GP interviewed commented on the progress and minimisation of infections for the size and nature of the service.</p> <p>The service was acknowledged and awarded the top two finalists for both categories (Build and Grown and Food Service) at the recent New Zealand Aged Care Association Conference.</p> <p>The service has also achieved five principles for the Eden alternative which they have developed and implemented in the last nine months, the day prior to this audit.</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>The open disclosure policy is based on the principles that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The registered nurses interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Family/residents interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. There was evidence of open disclosure and notifying family after an adverse event and/or through the incident/accident system, as explained by the registered nurse. Records were randomly selected and reviewed. The family communication records sheets are kept up-to-date.</p> <p>An interpreter service is available and accessible if required. The policy sighted makes reference to</p>

		the services complaints procedure.
<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>	CI	<p>This purpose-built facility opened in March 2015. The facility has a strategic plan 2015-2016 which identifies the purpose, values, scope, direction and goals of the facility. This plan is regularly reviewed with evidence of a selection of goals being achieved. Services are planned to ensure residents' needs are being met. The Eden Alternative is embedded into the governance of the facility and has been implemented system-wide.</p> <p>The facility is owned by two individuals. One owner works as the manager and the other owner assists with maintenance and oversees non-clinical issues. The management team, in addition to the owner/manager, includes a clinical nurse manager/registered nurse (RN), a quality manager/RN, an assistant manager, and an administration manager. They all have job descriptions which identify their authority, accountability and responsibility for the roles they undertake. The members of the management team are suitably qualified and/or experienced for their role.</p> <p>There are 82 licensed beds, which includes 20 dementia level beds in a secure dementia unit. On the day of audit there were a total of 79 residents living at the facility with 25 rest home level residents and 34 hospital level residents. There were 20 dementia-level residents (refer also to criteria 1.3.4.2 and 2.2.2.1).</p> <p>The owner/manager has 17 years of aged care experience in a management role. She was the owner/manager of three aged care facilities prior to the opening of Kumeu Village. She has maintained over eight hours annually of professional development activities related to managing an aged care facility.</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>The clinical nurse manager/RN is responsible for the day to day operation of the facility in the owner/manager's absence. She has worked in the aged care sector for the owner/manager for six years.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	FA	<p>A quality and risk management system is being maintained, which is understood and implemented by service providers as confirmed during interviews. The quality plan (2015) is linked to the strategic</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>plan. Policies and procedures are maintained by an external consultant who ensures they align with current good practice and that legislative requirements are met. The service personalises the policies to reflect service delivery at Kumeu Village.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Corrective actions are implemented and evaluated for areas requiring improvements. Information is shared with all staff as confirmed in meeting minutes and during interviews.</p> <p>Staff, resident and family/whanau interviews confirmed any concerns they have were addressed by management and examples of quality initiatives are documented in a register.</p> <p>A 2015 risk management plan is in place. Actual and potential risks are documented in the hazard register which identifies a risk rating and shows actions to eliminate or minimise the risk. Staff interviewed understood the process around reporting and managing newly found hazards.</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>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise future events and debriefing. Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Neurology observations were conducted for all suspected head injuries.</p> <p>The owner/manager and clinical nurse manager are aware of their responsibility to notify relevant authorities in relation to essential notifications. This has not been required.</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>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eleven staff files reviewed (one clinical nurse manager, six care partners, three RNs, one kitchen assistant) included evidence of the recruitment process, signed employment contracts, police vetting, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service.</p> <p>A register of current practising certificates for all health professionals is maintained.</p> <p>There is an annual education schedule that is being implemented meeting contractual requirements</p>

		<p>(refer to criterion 2.2.3.4). In addition, opportunistic education is provided. Discussions with staff and management confirmed that a comprehensive education and training programme in relevant aspects of care and support is in place. Two of eleven RNs have completed their interRAI training (refer to criterion 1.3.4.2).</p> <p>There are 15 care partners who work in the dementia unit. Four of the care partners have completed the required dementia qualification, nine are enrolled and eight who have been employed for less than six months are scheduled to enrol in 2016.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The clinical nurse manager (CNM) and quality manager are both RNs who work full time. A minimum of one RN is on site 24 hours a day, seven days a week.</p> <p>There are adequate care partners throughout the facility. The clinical nurse manager reports staffing levels in the dementia unit have been adjusted to care for 22 residents during the morning shift (to 6pm) with four care partners and a RN or EN scheduled for the day shift seven days a week (refer to criterion 2.2.2.1).</p> <p>Staffing is flexible to meet the acuity and needs of the residents. A casual pool of staff is available as needed. Agency staff are used due to current staffing demands. Interviews with residents and families confirmed staffing overall was satisfactory.</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>	PA Low	<p>Personal information currently is entered in all residents' files sighted. All entries are documented clearly and are legible with appropriate signatures and designations as required. The resident register is maintained. The personal files are normally locked in a cupboard in an open-planned nurses' station; however, during the audit the cupboard was open and the records were in public view. Legal documents such as service agreements and financial documents are stored in the main office in individual resident records in a locked cupboard and lockable room.</p> <p>The interRAI information system is being developed and introduced into the service. Resident individual records reviewed are integrated with information from the multidisciplinary team. A contents page is at the commencement of each individual record making information easily to be accessible as and when required.</p> <p>There are minimal archived records as the service has only been operating for nine months. Appropriate storage is available and records are able to be retrieved as necessary.</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>	<p>FA</p>	<p>The administrator/receptionist has an enquiry form that records pre-admission information. There is a current comprehensive information pack. There is adequate information about the service and the services provided along with the contact details for senior staff.</p> <p>The residents' service agreements randomly selected and reviewed is based on the Aged Care Association agreement which is individualised to the Kumeu Village. The admission agreements identify any additional charges that are not covered by the service agreement and the relevant costs of each charge required. Incontinence and wound care products are only charged if the resident or family chooses a brand that is different to those provided by the facility.</p> <p>All individual residents have been pre-assessed prior to entry to the service required, whether rest home, hospital and/or dementia level care. The GP interviewed reviews all residents on admission to the service in the required timeframes. The clinical nurse manager interviewed explained the admission process.</p> <p>Medical Services: The service is able to provide services for residents on a medical services agreement.</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>	<p>FA</p>	<p>The clinical nurse manager interviewed stated risks are identified prior to planned discharges. A transfer form is used and the `yellow bag system` for transferring a resident to the DHB. This process works effectively and safely when transferring to the DHB. A copy of the medication records and care plan summary is provided that covers all aspects of care provision and intervention requirements, including any known risks, allergies/sensitivities or concerns. A copy of any advance directives also accompany the resident if they are transferred to hospital. Family/whanau are kept well informed of any transfer and/or discharge.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy provides guidance on medication reconciliation, prescribing, ordering, checking, storage, administration, and documentation of medications. The process for disposing expired, unwanted medication is also noted. Residents have the right to refuse medications. Where a resident refuses medications, this must be documented and communicated. This is flagged on the electronic medication system utilised. Any medication errors are required to be reported via the incident reporting system. The management of controlled medication includes the weekly checks of balances and the six monthly quantity stock count.</p> <p>No residents are self-medicating medication. A process is in place should this situation arise.</p> <p>Medicines are received from the pharmacy two weekly in a pre-packed delivery system. A safe system</p>

		<p>for medicine management was observed on the days of the audit. Medicines are stored in a locked medication room. The medication trollies are stored in the room when not in use. A medication fridge is monitored appropriately and records are maintained. Medication records reviewed evidenced allergies/sensitivities are entered for each resident or 'nil known' documented.</p> <p>The GP interviewed ensures the medication reviews are completed at least three monthly and this was observed on the medication records reviewed electronically. The Clinical Nurse Manager (CNM) is able to access all medication records electronically and the electronic process was fully demonstrated. Any medication commenced or discontinued must have a reason documented. All electronic competencies are signed off by the CNM. All RNs, enrolled nurses and senior care partners have completed competencies. Ongoing education is provided. Medication audits are performed monthly and five residents' medication records are reviewed by the CNM.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>CI</p>	<p>The food service is managed by three cooks who are well supported by the kitchenhands. The two cooks interviewed explained the food service processes. On admission a nutritional assessment is completed by a registered nurse for each individual resident to identify any food allergies/sensitivities and/or preferences. A copy is provided to the kitchen staff.</p> <p>The food service manual reviewed identifies the policies and procedures and schedules for cleaning the kitchen and equipment daily. The policy details the principals of food safety, ordering, storage, cooking, reheating, waste management and food handling. Infection prevention and control requirements are also detailed. Guidance is provided on puree diets, soft diets, diabetic diets, light diet, reducing diets and a normal diet. Portion sizes are included as well as practices to ensure residents remain appropriately hydrated.</p> <p>There is evidence of regular monitoring and surveillance of the food preparation and hygiene performed. The fridge, chiller and deep freezers are closely monitored daily. The cooks and kitchen staff have completed appropriate training. Certificates are displayed in the kitchen and information is retained in the staff records reviewed.</p> <p>A four week winter menu is displayed in the kitchen and also on the notice board near the dining rooms in the rest home/hospital and memory loss house. The summer menu is currently being developed. The menu plans are reviewed by a registered dietitian. The cooks report on interview that they are well supported by management and respond to all concerns expressed by residents relating to the food service.</p> <p>When unintentional weight loss is recorded, the resident is referred for a dietitian review (evidenced in residents' records reviewed). A weight monitoring chart is used by the nursing staff to monitor progress and this is reported to the GP.</p>

		<p>The family and residents interviewed reported they are more than satisfied with the food and fluid service. The residents also have the opportunity to be part of the menu development through the residents' meetings and suggestions offered.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The entry criteria is known to all staff interviewed. The staff reported that the service does not refuse a resident if they have a suitable needs assessment service coordination assessment (NASC) for the level of care required and that there is a bed available at the time.</p> <p>In the event that the service is unable to meet the needs of the resident, the resident, family and the NASC will be contacted so that alternative placement can be arranged. Records are kept if this event should occur.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>All assessment tools are appropriate for the three levels of care provided. Initial assessments includes falls, skin integrity, challenging behaviour, nutritional needs, continence, communication, end of life and pain management. Assessments are undertaken by the registered nurses. The registered nurses are each responsible for a number of residents to ensure all care and needs are able to be effectively met. Currently only two registered nurses have completed the relevant compulsory interRAI training effective from 1st July 2015.</p> <p>The resident records reviewed have initial assessments that include identifying behaviour particular to an individual resident. In specific cases, residents who are assessed with challenging behaviours an ongoing care review and specialised behaviour assessment is utilised. The behaviour assessments sighted included the triggers, description of behaviour, contributing factors and solutions inclusive of de-escalation techniques.</p> <p>The records reviewed have assessment information that is obtained from previous care partners, services, and where applicable, the family or nominated representative.</p> <p>The service has a continence assessment and management procedure, wound care management procedures and protocols and behaviour management processes which includes seeking expert assistance as required. Where a need is identified, interventions for this are recorded on the care plan. All of the records reviewed have falls risk assessments and pressure risk assessments.</p> <p>Medical services: Full interRAI assessments would be performed on all residents admitted with high medical needs. The clinical nurse manager reports that they would oversee all residents' care and management.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The residents' records have care plans that address resident's current abilities, level of independence, identified needs/deficits, and take into account the resident's habits, routines and idiosyncrasies. Strategies for minimising risks are utilised. The interRAI assessment, if completed by the registered nurses, has an assessment summary which includes triggered outcome scores and the needs for the resident involved. These findings are documented onto the care plan.</p> <p>The objectives of the Eden Alternative are also embedded into the care and activities plans for each resident. The activities plans identified motivational and recreational requirements and how these are managed effectively for the individual resident. Appropriate interventions were documented on each care plan sighted.</p> <p>The strategies for minimising episodes of challenging behaviours are based on assessment, prevention and de-escalation techniques and activities that are effective for the resident (evidence in the memory loss records reviewed).</p> <p>The clinical and non-clinical staff interviewed report they receive adequate information to assist the continuity of care. The handover and communication book observed includes updates on all residents as required.</p> <p>The individual resident's records sampled (inclusive of the three records reviewed in detail) demonstrated integration and dividers between each section and a contents page with a list of contents to facilitate easy access to records.</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>Policies and procedures for managing challenging and disruptive behaviour and pain management are supported by relevant assessment tools. A suite of clinical management policies and procedures includes assessment on admission, weight and bowel management, wound care, skin integrity and managing skin conditions, clinical notes and referral information.</p> <p>As observed on the days of the audit and review of the care plans, support and care is flexible and individualised focusing on the promotion of quality of life. The registered nurses and care partners interviewed demonstrated good knowledge and skills managing service delivery for residents of three levels of care.</p> <p>The records reviewed evidence involvement of the family. The residents interviewed reported that the staff 'buddy' system with residents provided a supportive relationship that reduced anxiety and maintained a sense of trust, security and self-worth.</p> <p>The service provider has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed record interventions that are consistent with the residents'</p>

		<p>assessed needs and desired outcomes.</p> <p>The registered nurses and the clinical nurse manager report that the care plans are accurate and up-to-date. Reviews are undertaken as per the review schedule sighted and earlier if and when required.</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>CI</p>	<p>The lifestyle calendar (one of two) was sighted and displayed on the notice board. The programme is flexible with numerous events planned effectively to celebrate social highlights and Eden moments. The Eden Alternative is well embedded in the organisation in every aspect of service delivery.</p> <p>Activities are developed and implemented to meet the needs of residents, inclusive of enhancing individual resident's skills, strengths and interests. There are planned activities balanced with spontaneous activities to alleviate boredom. The memory loss house newsletter is well received with photographs of activities shared and information for families and residents.</p> <p>The lifestyle programme extends over the twenty four hour period for the memory loss house (dementia service). The outdoor area is well designed with a pathway that enters and exits from the main lounge area. A post box and seating is available for residents as they walk around the grounds in the secure and safe environment.</p> <p>Daily activities attendance records are maintained and reviewed at the end of each month to assess the enjoyment and interest of the elders/residents. There are group and individual activities that focus on sensory activities and reminiscence. The two of four activities coordinators interviewed reported they try to engage residents' interests and long term memories. The map of life is completed on admission and kept in the front of each resident's record.</p> <p>Community connections is paramount and outings are arranged on a regular basis in the ten seater van on Tuesdays and Thursday weekly. Where possible residents are encouraged to maintain links with their family and family can join in the programme. Monthly church services are held which are interdenominational.</p> <p>Entertainers are welcome to visit the home and there is lots of interactions observed with local schools and pre-schools in the area. The care partners have a buddy system with a resident. Each forms a relationship and connection with a resident and this is working well.</p> <p>The residents' have their own council and council members meet regularly on a monthly basis and a full residents meeting is held quarterly. Minutes are maintained. Residents also discuss and make contributions to the lifestyle programme.</p> <p>A pet programme including a puppy day care, cats, birds and two Shetland ponies promote purposeful activities. The staff are proud of all the new initiatives now included in the lifestyle programme over the</p>

		<p>last nine months.</p> <p>Family and residents interviewed report that they enjoy a range of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The resident records reviewed evidenced timely evaluations. The home has been in operation for nine months. A schedule is developed and implemented and each registered nurse is allocated residents to be responsible for the evaluations each six monthly and as required. The evaluations are reviewed for all of the issues on the care plan. These evaluations are resident focused and indicate the degree of achievement and/or response to supports/interventions and progress towards meeting the desired outcomes. Some records evidence interRAI assessments but this is work in progress as only two registered nurses have completed this training (Refer criterion 1.3.4.2).</p> <p>Short term care plans are developed and implemented for wound care, pain management, infections, changes in mobility, changes in oral intake and skin care. These processes are documented on the short term care plan, medical and nursing assessments and the progress records.</p> <p>The care partners interviewed demonstrated knowledge of the short term care plans and report issues as observed to the registered nurses. Family are kept up-to-date and this is documented on the family communication record and in the progress records. Family participation in the six monthly multidisciplinary reviews is welcomed.</p> <p>If a resident is not responding to the interventions being delivered or their health status changes, then this is discussed with the GP. The GP interviewed reported that the communication has improved with the registered nurses employed, as all staff are learning new processes. The GP is available to speak with family as arranged.</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>The residents are provided with options if they are required to access other health and disability services (e.g., public or private). There is one contracted GP who visits the service every day. The GP arranges all referrals to specialist services when it is necessary. The GP interviewed reports that referral services respond promptly to referral sent. Records of the process are maintained as confirmed in resident records reviewed which includes referrals and consultations with radiology services, gerontology nurse specialist, wound care specialist, podiatry and dietitian.</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>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning chemicals and chemicals are stored securely. Laundry services are contracted off-site. Sluice rooms are kept locked with electronic access. Product use charts are available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.</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>The facility was a finalist in the Aged Care Conference awards under the division of 'Built and Grown Environment' 2015.</p> <p>The service displays a current code of compliance which expires on 20 February 2016. An approved fire evacuation plan was sighted (21 January 2015).</p> <p>Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested and tagged. Calibration of equipment is scheduled to occur annually. The service has a van used for resident's outings that has a current warrant of fitness and registration. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Care partners interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>The dementia unit has several areas designed so that space and seating arrangement provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required including individual rooms. There is a safe and secure outside area that is easy to access.</p> <p>This audit confirmed the dual purpose residents' rooms are suitable for hospital level care under the medical contract.</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</p>	FA	<p>All bedrooms are single with a shared toilet for every two rooms. Toilets and showers have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. Shower facilities are located in each wing at a ratio of one shower to every five residents.</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The residents' rooms are spacious enough to meet their assessed needs. Ten rooms that are suitable as double rooms are currently being used as single rooms. Residents were able to manoeuvre mobility aids around the bed and personal space. All beds were of an appropriate height for the residents. Care partners interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are lounges and dining rooms in the hospital, rest home and dementia areas. There are smaller quieter comfortable seating areas throughout the facility for residents and visitors. Dining rooms are spacious and located directly off kitchen/server areas. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed reported they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p> <p>The dementia unit provides adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Kumeu Village has monitored the effectiveness and compliance of cleaning policies and procedures. Laundry services are contracted off-site. Staff have attended infection control and chemical education. There was appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency and disaster policies and procedures are in place. An approved fire evacuation plan is in place. Fire evacuation drills take place every six months at a minimum. The orientation programme and annual education and training programme include mandatory fire and security training. Staff interviewed confirmed their understanding of emergency procedures.</p> <p>Required fire equipment was sighted and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency</p>

		<p>including food, water, blankets and gas cooking. A generator is available for emergency power.</p> <p>An electronic call bell system is in place. Residents were observed to have access to their call bells in their rooms.</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>	FA	<p>All communal areas and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</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>	FA	<p>The service has a documented infection control programme which has been reviewed and signed off by the Manager. The infection control programme aims to minimise the risk of infections for residents, staff, family/whanau and visitors to the facility. The organisation is a member of an external specialist infection control service.</p> <p>The Infection Control Co-ordinator (ICC) is the Clinical Nurse Manager (CNM) who is a registered nurse. A job description is available which states guidelines for the accountability and responsibilities involved with this role. The ICC interviewed demonstrated good infection prevention and control understanding and awareness of standard precautions. The ICC monitors all infections, uses standardised definitions to identify infections appropriately, surveillance and monitoring of organisms, related to antibiotic use. Monthly records are maintained and were reviewed. Infection control is presented at each staff and quality meetings. Minutes were available and sighted.</p> <p>The ICC and registered nurses interviewed reported that staff fully support the programme and have good assessment skills in the early identification of suspected infections. This was also addressed with the care partners interviewed who stated that they notified the registered nurses if any concerns arose when caring for the residents. The shift handover observed is a forum for reporting incidences of infection. Short term plans are used, for example for wound care and other infections.</p> <p>Infection control advice can be sought from the GP interviewed, the laboratory microbiologist, a team member of the specialist advisory service, and from the infection control team at the DHB when required. The GP interviewed is well informed of obligations and reporting systems if needed for notifiable outbreaks or diseases. There have been no outbreaks of infection since the last audit.</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 clinical nurse manager has the role of infection control co-ordinator. The infection control committee meets monthly and any issues are reported at the staff meetings. The infection control committee consists of three registered nurses, two enrolled nurses and one care partner. External specialist advice is available if and when required from the DHB infection control team, the diagnostic service and the GP. The externally contracted specialist infection control advisor also provided a study day opportunity for the staff to attend. Records of attendance were maintained. The CNM, clinical and non-clinical staff interviewed demonstrated good knowledge of infection prevention and control.</p> <p>A process is identified in policy for the prevention of exposing other to infection. Staff interviewed knew when not to come to work and when to return. Signage is used in the facility when required. Sanitising hand gel is available throughout the facility and there is adequate handwashing facilities for staff, visitors and residents. Some bathrooms have sensor non-touch taps and sensor paper towel dispensers.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual was developed and implemented when the service commenced operation nine months ago. The policies and procedures set out the expectations the service uses to minimise infections. This is well supported by specific infection control areas, such as antibiotic use, methicillin resistant staphylococcus aureus (MRSA) and other antimicrobial screening, wound care management, blood and body spills, cleaning and disinfection are covered. Laundry and cleaning policies and procedures are developed and implemented specifically for the relevant services provided. The policies and procedures are accessible for staff.</p> <p>Visual inspection at the onsite audit identified implementation of infection prevention and control procedures. All staff demonstrated safe and appropriate infection prevention and control 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>Infection control education is provided in the orientation programme and is part of the ongoing education schedule for 2015 – 2016. The infection prevention and control education has been provided by the specialist infection control advisor and the ICC. Education was verified in the staff records reviewed.</p> <p>The ICC clinical and non-clinical staff interviewed demonstrated good knowledge of infection preventions and control. Resident education is conducted as required. Hand hygiene is promoted and encouraged for all staff in all areas of the service.</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>Policy identifies that surveillance data is used to identify any trends and corrective planning is put in place as appropriate. The service has a system in place to ensure infection control is managed by an experienced registered nurse who is the CNM.</p> <p>A notification of infection form is completed by staff as soon as signs and symptoms have been identified and given to the ICC. Monitoring is described in the infection control plan to describe actions taken to ensure residents` safety. The ICC completes the monthly infection surveillance report. The ICC monitors all urinary infections (UTIs), eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections. For any use of an indwelling urinary catheter risks are minimised with good techniques utilised by staff undertaking procedures as needed. The monthly analysis of the infections includes comparison with the previous month, reasons for the increase or decrease of infections and actions taken to reduce infections. The analysis includes the feedback summary that is provided to all staff at the staff monthly meetings. Graphs are used for visual impact with the infection rates recorded on a per1000 bed days for the month and over the year.</p> <p>Benchmarking is used for quality improvement if required and to ensure the service is managing infection prevention and control adequately to ensure risk is minimised, and this is clearly evident in the summary results sighted.</p> <p>The surveillance programme reviewed is appropriate for the size and nature of this type of aged care residential facility and the services provided.</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>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in the Standard (NZS 8134.0). The policy includes comprehensive restraint procedures. Interviews with the care partners and nursing staff confirm their understanding of restraints and enablers (refer to 2.2.3.4). Interviews with the restraint coordinator and staff confirms their understanding of restraint minimisation (refer to 2.2.2.1 and 2.2.3.4).</p> <p>The service has eight hospital-level residents using bedrails as an enabler and three hospital level residents using restraints (refer to 2.2.2.1). Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents.</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	<p>FA</p>	<p>A restraint approval process is in place. The restraint coordinator role is delegated to the clinical nurse manager. All staff are required to attend restraint minimisation training annually.</p>

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Low	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool is in place, which meets the requirements of the standard.</p> <p>Two files of residents using restraints were reviewed and reflected appropriate assessments and consents with links to their care plans.</p> <p>One rest home level resident and one hospital level resident spend their days in the secure dementia unit. Environmental restraint is not included in the restraint policies and procedures and restraint assessments and consents were not completed.</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Moderate	A restraint register is in place. The register identifies three hospital-level residents as using either a bed rail (two residents) or a lap belt (one resident) as restraint. The assessment identified that restraints are being used only as a last resort. The restraint assessment and on-going evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. A completed monitoring form for the day shift was missing for one hospital level resident wearing a lap belt. Staff interviewed in the dementia unit were unaware that this documentation was required to be completed. The auditor was unable to determine how frequently the lap belt was released during the day.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed three monthly by the restraint coordinator. Strategies are implemented to reduce restraint use. At the time of the audit, only three residents were using a restraint.
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	The restraint programme, including reviewing policies and procedures and staff education is reviewed by the restraint coordinator. The programme has been developed by an external consultant and has been modified to meet the needs of the facility (refer to 2.2.3.4). Staff training, which begins during the

Services demonstrate the monitoring and quality review of their use of restraint.		new employee's induction, is scheduled to take place annually (refer to 2.2.3.4).
---	--	---

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.7</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	PA Low	The personal residents' records containing service agreements and financial records are stored out of public view in a locked cupboard within an office that is lockable. These records are able to be accessed by management and the administration manager as required. The records for the rest home and hospital level care residents are accessible from a cupboard in the open planned nurses' station.	The integrated individual records for the rest home and hospital level care residents containing personal information, were not maintained in a secure manner and were accessible to the public and/or residents at the time of the audit.	<p>Provide evidence that a system is in place to ensure the personal resident records are maintained in a secure manner that is not publicly accessible or observable.</p> <p>180 days</p>

<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>All assessment processes and tools are available for the three levels of care provided for residents. Assessments are undertaken by registered nurses all who are allocated to specific residents in the home. The number of residents are divided evenly between all registered nurses to ensure all reviews are undertaken to meet the needs of the residents. A schedule is being developed for the interRAI assessments to be completed but has not been implemented as yet.</p> <p>The memory loss house has full occupancy. A placement issue of two residents was observed. The two residents are placed in memory loss house during the daytime. One resident (hospital level) has already been assessed as requiring memory loss services (no bed is available) and the other (rest home level) is currently better managed in this care setting more appropriately than in the rest home/hospital section</p>	<p>There are two findings to be addressed. Currently only two registered nurses of eleven employed, have completed the required interRAI training therefore not all residents admitted to this facility have had an interRAI assessment completed in a timely manner.</p> <p>Two residents are being cared for in the memory loss house during the day. One resident has been assessed but there are no beds available in this service. The other resident is currently assessed as rest home level of care but is currently being managed in the dementia service for safety purposes. Reassessment is required to ensure appropriate placement for this resident.</p>	<p>Ensure an adequate number of registered nurses have completed the required interRAI training, and that all residents undergo an interRAI assessment on admission, and for the six monthly review process and subsequent reviews as necessary.</p> <p>Ensure appropriate assessments are able to be validated, as well as documented information from the WDHB to evidence these reviews have occurred.</p> <p>180 days</p>

		of the home and needs to be re-assessed.		
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	PA Low	<p>Policies and procedures are in place for restraint minimisation but do not include aspects of environmental restraint. Appropriate assessments are completed for residents using restraint meeting criteria a) – h) of this Standard, although assessments were not completed for one hospital level resident and one rest home level resident who spend their days in the secure dementia unit.</p>	<p>During the audit a hospital resident and a rest home resident were sighted to be in the dementia unit. This is environmental restraint. The restraint coordinator reports that this has been approved by the NASC but that she was unaware restraint processes were required to be put into place. The restraint policies do not include environmental restraint and the residents have not been assessed for environmental restraint. The use of the environmental restraint and ways to manage the risks of this were not included in the resident's care plan.</p> <p>During the audit, restraint assessments were completed for these two residents and consent processes were confirmed via email.</p>	<p>Ensure environmental restraint is covered in restraint minimisation policies and procedures. Ensure applicable residents have an appropriate assessment and consent for environmental restraint and that the care plan includes the use of environmental restraint and ways to manage any potential risk of this.</p> <p>90 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p>	PA Moderate	<p>The restraint assessment form includes the frequency of monitoring residents while restraint is in use. Completed monitoring forms were</p>	<p>One hospital-level resident using a lap belt as a restraint is not being monitored during daytime hours when they are in the dementia unit, as evidenced on the monitoring form. Staff</p>	<p>Ensure staff in the dementia unit are made aware of the use of restraint monitoring forms</p>

<p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>		<p>sighted for two hospital-level residents. Missing was evidence of a completed monitoring form of a lap belt for the day shift in the dementia unit. Staff interviewed were unaware that this needed to be completed (refer to 2.2.2.1).</p>	<p>interviewed were unaware that they needed to be completing this form. The auditor was unable to determine how often the resident's lap belt was released during while they were in the dementia unit.</p>	<p>and that any residents using lapbelts as a restraint are released from the restraint, as determined by their restraint assessment.</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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	The Eden Alternative has been embedded into practice.	The service has exceeded the required standard through implementation of the Eden Alternative which is embedded throughout the facility, both in a physical sense and from a cultural perspective. Kumeu Village underwent their Eden Alternative audit prior to this full certification audit and achieved five of ten principles (principles one, two, four, five and six) which the owner/manager reports is the first time this outcome has been achieved for a new facility in New Zealand. The environment, the dining experience and the activities programme were awarded as finalists in the Aged Care Association Awards 2015. Resident and family surveys conducted reflected results that exceed benchmarked results against other facilities operating as an Eden Alternative facility.

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>In addition to meeting the requirements of the service agreement the organisation has many initiatives planned and implemented to meet the nutritional needs of the elders/residents. The introduction of the Eden Alternative philosophy and initiatives has led to significant changes in the way the food service has been delivered successfully. As the service has only been in operation for nine months the food service has grown with the numbers of residents being admitted (currently 79). The lay out of the kitchen in relation to the services is well designed with the kitchen being the centre hub of the home. This provides a home-like environment Two serveries sighted are functional and ensure the meals are able to be served directly to the residents in the memory loss house and the rest home/hospital at the same time with assistance of all the staff in the kitchen and the dining room.</p> <p>Guidelines and input from the residents has ensured the menu development is planned to meet the resident`s needs as well. The service has recently been recognised at the Zealand Aged Care Association (NZACA) conference for initiatives for service delivery, inclusive of the foodservice.</p>	<p>A continuous improvement rating is made beyond the expected full attainment for an excellent food service that is co-ordinated in a manner that provides and promotes a team approach of service delivery and more than meets the expectations and needs of the residents. The home was recently awarded a food excellence award and recognition from the new Zealand Aged Care Association (NZACA) conference. The award was awarded for the following reasons such as the use of organic produce, fresh produce, relaxed dining times, open kitchen, resident self-service buffets, weekly carvery`s, choose your own and make your own – toasties and pancake nights, themed dinner nights, a café and a le carte menus for visitors as well as residents, kiosk, ice cream machine, table settings, sparkling water machine, exquisite high tea (twice weekly), resident input into theme menu planning and resident dining room assistants. The feedback from resident council members, residents/family and staff was positive about the food service.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>The map of life information from the initial assessment provides the basis of planning the lifestyle programme. The staff and residents are very enthusiastic about the Eden Alternative and principles being included and embedded into each area of service delivery. Lots of celebrations and events were in action during the audit. In addition the festive and Christmas theme and decorations were evident in all services with music and decorations throughout the facility. The notice board displayed the resident council members, the residents` rights charter, special celebrations such as birthdays, the menu for the day and special events up-and-coming.</p>	<p>A continuous improvement rating is made for achievement beyond the expected full attainment for the planned and spontaneous activities facilitated to develop and maintain strengths, skills and interests that are meaningful to the elders/residents in the memory loss house and for residents that are assessed as requiring rest home and hospital level care. Staff involvement includes activities co-ordinators, care partners and RNs. The facility is introducing the ten Eden principals, Eden moments, Eden initiatives such as the transformation and fitness programme and pet day care/pet programme. Five lifestyle team members and one elder are training in-house to</p>

		<p>Photographs adorned the photo-board of residents and staff having fun. The memory loss house was busy with numerous activities in progress. The house was divided into sections such as the kitchen (accessible to residents), library and children's corner. Resources are stored which are accessible for use over the twenty four hour period.</p>	<p>become qualified fitness in the community instructors and hydro-therapists. Two staff are responsible for the animal welfare and assist the residents involved. Staff interviewed reported immense satisfaction with the buddy system and the lifestyle programme. The home has recently been awarded success by achieving five of the Eden principles in a relatively short timeframe.</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>CI</p>	<p>This purpose-built facility, which opened in March 2015, has design features that are linked to the Eden Alternative and exceed customer expectations.</p>	<p>The service has exceeded the required standard by maximising the environmental objectives of efficiency, comfort, generous sized bedrooms, flow and low maintenance. The facility is on one level. A range of suitable areas are available for exercising indoors and outdoors. This included the development of a gym, hydrotherapy pool, outdoor and indoor courtyards, walking paths and paddocks/pens. Views of the gardens, landscaped courtyards, countryside, or vineyards are visible from every room. The facility opened on the 9 March 2015 and full occupancy was achieved on 9 July 2015. As a result of this purpose build facility, feedback from residents and families via interviews and satisfaction surveys is overwhelmingly positive. The facility was also a finalist in the Aged Care Association awards in the 'Built and Grown Environment' division.</p>

End of the report.