

Kamo Home & Village Charitable Trust - Kamo Home and Village

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: Kamo Home and Village Charitable Trust

Premises audited: Kamo Home and Village

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

Dates of audit: Start date: 20 January 2016 End date: 21 January 2016

Proposed changes to current services (if any): There has been two reconfigurations to make a total of 10 rest home beds being reconfigured to rest home/hospital (dual purpose) level. This changes the facility configurations to a 24 dementia unit, 10 beds that are rest home level of care only and the remaining 35 beds are dual purpose (rest home or hospital level of care).

Total beds occupied across all premises included in the audit on the first day of the audit: 66



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kamo Home and Village is owned and operated by a charitable trust, located within a retirement village complex. The service provides rest home, specialist secure dementia care and hospital level of care for up to 69 residents.

A full certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included the onsite audit and the review of documentation, observations and interviews. Interviews were conducted with the management, clinical and non-clinical staff, residents, family/whanau and a general practitioner to verify the documented evidence. This audit report is an evaluation of the combined evidence on how the service meets each of the standards.

There are no required improvements identified at this audit. The strengths of the service include the care planning processes, the activities programme, the implementation of the quality systems and staff training.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. The advocacy service visits every six months for staff education and attendance at residents' meetings. All staff interviewed understood residents' rights. The service has an easy to use complaints management system. There is a complaints register that contains any complaint received and actions taken to address any shortfalls

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.		All standards applicable to this service fully attained with some standards exceeded.
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Organisational structures and processes are monitored at the management and board levels. Service performance is aligned with the recognised business excellence frameworks, the organisation's philosophy and goals identified in the quality and risk plan.

Kamo Home and Village has a robust documented and implemented quality and risk management system that supports the provision of clinical care and support. The service has gained two ratings beyond the required full attainment for the extensive continuous quality improvements and promotion of staff involvement in the quality and risk programme.

The general manager is suitably qualified and experienced to run the service. The general manager reports to the Board of Trustees. The general manager is also supported by the clinical and non-clinical members of the management team.

Policies are reviewed by the management team annually and quality and risk performance is reported through meetings at the facility and monitored by the management team. Review of service delivery includes incidents/accidents, infections, complaints and reports from the internal audit programme. The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There is adequate staff numbers each shift to meet the residents' need at the various levels of care. The education programme for all staff is available and planned for the year. Staff education is encouraged. The education, training and orientation processes for staff have undergone extensive review, are linked to the organisation's strategic directions and are achieving improved outcomes for residents. The education system has also gained a continuous improvement rating.

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.		All standards applicable to this service fully attained with some standards exceeded.
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The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital, dementia and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. The

general manager and clinical manager oversee the care and management of all residents, along with a team of staff. All residents are assessed on admission and assessment details are retained in the individual resident's record.

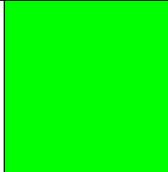
The residents' care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The residents and families interviewed reported they are involved in the care planning and review. This area is rated as continuous improvement. The general practitioner (GP) ensures all residents are seen on admission and provides full medical cover for all residents 24 hours a day. Documentation is reviewed within timeframes as required.

The activities available are appropriate for residents requiring hospital, dementia and rest home level care. The lifestyle manager oversees the programme for the residents. The programme is a strength of the service and is rated as continuous improvement.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo a competency assessment annually. The registered nurses (RNs) and clinical manager are responsible for all areas of medication management and work alongside a contracted pharmacy.

Food is prepared on site and overseen by two cooks over seven days. The menu plans have been reviewed by a dietitian. Each resident is assessed by the RN and clinical manager on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. The two cooks have completed food safety training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All building and plant complies with legislation with a current building warrant of fitness displayed. Ongoing maintenance ensures the building is maintained to meet the needs of the residents. Fixtures, fittings, floor and wall surfaces are made of acceptable materials for this environment. All rooms have access to hand basins. One wing has full ensuite facilities for all the rooms. There are adequate toilets, showers, and bathing facilities located through the facility that provide adequate privacy.

The environment is appropriate for rest home/hospital and specialist dementia level of care services. All areas ensure physical privacy is maintained and have adequate space and amenities to facilitate independence. There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances, and to provide safe and hygienic cleaning and laundry services.

The facility has an appropriate call system installed. There is easy access to external gardens, grounds and court yards for residents and their visitors. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents. The secure dementia unit is separated from the rest home/hospital sections.

Routine safety checks and internal audits are performed by maintenance personal and management. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

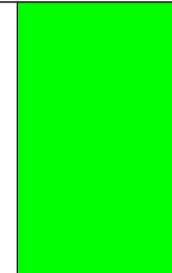
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service operates a restraint free environment and has no recorded restraint. The use of enablers are voluntary and the least restrictive option to maintain resident safety, comfort or independence. Clear definitions in the policies ensures staff understand the implication of restraint and enabler use.

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.

There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff. Infection control education is provided by the infection control coordinator who is responsible for infection prevention and control activities. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The GP, or other specialised input, is sought as required. Staff and residents report on interview they are informed of any infection issues within the facility.

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	42	0	0	0	0	0
Criteria	6	87	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents interviewed reported that they are treated with respect and understand their rights. The relatives interviewed reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Evidence is seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where</p>

		<p>applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. The GM discusses information on informed consent with the resident and family on admission. An advance directive enables a resident to choose if they would like active medical treatment to prolong life, transfer to base hospital for on-going treatment or receive 'comfort care'. The files reviewed have signed advance directive forms which meet legislative requirements</p> <p>Family members and residents are actively involved and included in care decisions as evidenced in residents' files reviewed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons. This was confirmed in interview with residents.</p> <p>Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed report knowledge of residents' rights and advocacy service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents reported on interview that they are supported to be able to remain in contact with the community by outings and the walks to local shops and parks. Policy includes procedures to be undertaken to assist residents to access community services and a van is available.</p> <p>There is portable phone which is taken to the residents as required.</p> <p>Evidence in files reviewed shows attendance at DHB for appointments as required.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints register and sample of complaints for 2015 evidences that complaints are managed within time frames of Right 10 of the Code. Complaints forms are available at the entrance, with information given on the complaints process as part of the admission procedure and advocacy session with residents and families.</p>

		<p>Residents and family/whanau report they are encouraged to provide feedback or make a complaint.</p> <p>The service has had external complaints since the last audit. One of these complaints has resulted in a corrective action plan to addresses the concerns, the implementation of these is being monitored by the DHB. The service's imbedding of the corrective action plan and process is evidenced at the time of audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families (as confirmed by interview with the general manager (GM)). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Residents are addressed in a respectful manner and by their preferred names as was confirmed in interview with residents.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed.</p> <p>Evidence is seen in files reviewed of the residents' goals which are personalised and reviewed every six months.</p> <p>Staff interviewed report knowledge of residents' rights and understand dignity and respect.</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 cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery/decision making is sought if applicable.</p>

		<p>There were no Maori residents in the service at the time of audit.</p> <p>Education was given to staff on the Treaty of Waitangi in 2015 and staff interviewed reported that they understand the Treaty of Waitangi and attend the education annually.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The clinical manager (CM) or RN assess the cultural and/or spiritual needs of the resident in consultation with the resident and family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident.</p> <p>If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided as confirmed in interviews with hospital and rest home residents and dementia unit relatives, and review of satisfaction surveys.</p> <p>Staff interviewed reported on the need to respect individual culture and values.</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 employment position description and the Code of Rights define residents' rights relating to discrimination. Staff interviewed verbalise they would report any inappropriate behaviour to the general manager (GM). The GM reported she would take formal action as part of the disciplinary procedure if there was an employee breach of conduct. There was no evidence of any behaviour that required reporting and interviews with residents indicated no concerns.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Care staff have undertaken or are completing the National Certificate in the Care of the Elderly Education programme. All staff have an up to date first aid certificates and all staff who administer medication have yearly assessments to determine competency.</p> <p>The CM and RNs attend education sessions run by hospice and other local organisations. The planned yearly education programme</p>

		<p>reviewed included sessions that ensures an environment of good practice. The food service cooks have fulfilled the requirements of safe food handling. Residents' satisfaction surveys show evidence that they are satisfied with the meals and food supplied.</p> <p>Policies and procedures reviewed are all current and relate to best practice. There is specialist advice available if required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The cultural policy notes interpreters will be accessed if required. Prior to admission of residents, who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. These can be contacted via the DHB.</p> <p>Evidence is seen that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. Staff make adequate time to talk with residents and families as confirmed in interviews with staff and the CM. There is sufficient space in each single room to permit private discussions and a telephone is available for the resident's use.</p> <p>Family members are used as interpreters, where appropriate, and with prior consent. If necessary, an interpreter within the community or staff is sought. This was confirmed in interview with the GM.</p> <p>Evidence is seen of open disclosure on consent forms signed by residents or families.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The services are planned to meet the individual needs of each of the residents. There is a specialist secure dementia care unit, and three wings for either rest home or hospital level of care. One of these wings (Tuatara Court) also has independent living units. At the time of audit there were 16 rest home level of care, 27 hospital level of care and 23 dementia level of care residents. These include three residents who are under the age of 65 and one resident on a contract for medical care. Although there are 35 dual purpose beds, the service does set their maximum hospital level of care at 30.</p> <p>Appropriate processes, staffing and resources are in place to meet the needs of all the residents. The service, where possible, groups the rest home and hospital level of care residents together. Two wings are predominantly hospital level of care and one mostly rest</p>

		<p>home level of care. Where rest home residents are in predominantly hospital wings, processes are implemented to ensure these residents participate in social activities suitable to their individual needs and have the option to have meals in the main dining room.</p> <p>The mission, vision, values, philosophy and purpose are clearly shown. The strategic plan documents long term, medium term and short term strategies to achieve set goals and mitigate known risk to all areas of service delivery. The business plan focus includes goals in the environment, service provision and human resources, which is linked to the overall long term strategic plan. The business plan is reviewed annually by the Board of Trustees. Strengths, risks and opportunities are clearly identified. Key performance indicators are developed and based on an internationally recognised quality business excellence framework to match the business plan. These are reported and measured as identified on the care and processes matrices, balanced score card and external benchmarking.</p> <p>The service is managed by a suitably qualified and experienced general manager who is a registered nurse. The general manager has the responsibility for the overall management of the service and reports to the Board of Trustees. There is also a management team that consists of the clinical manager, quality manager, lifestyle manager and administration staff. The general manager's job description outlines their role and responsibilities for the management of the service. The general manager has attended over eight hours education related to the management of aged care services, their responsibilities to provide aged care services with the DHB and they attend other clinical education related to dementia and aged care.</p> <p>The residents and family/whanau interviewed and satisfaction surveys report satisfaction with the quality of care and services provided at Kamo Home and Village.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The other members of the management team take on the management roles when the general manager is on leave. As a backup for the members of the management team the chair of the board is available for advice and consultation. The general manager reports confidence in the management team to take on the general</p>

		manager's role during their temporary absence.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	CI	<p>The staff and members of the management team demonstrate an understanding of the quality and risk processes that are identified in policy. Staff at all levels of the service report their involvement with the ongoing quality and risk management systems. Staff stated that quality improvement was a team effort, they had increased their knowledge in this area, and that they had a better understanding of quality and risk and the significance for gaining better outcomes in care and service delivery.</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals and reflect legislative changes.</p> <p>The service has robust systems implemented for quality management, the collation and analysis of data, and processes to measure achievement against the quality and risk management plan and strategic directions.</p> <p>The organisation has an up to date risk register and quality and risk plan which identifies actual and potential risks for all levels of service. Minimisation strategies have been put in place as required. Staff education includes risk management processes. Interviews with five of five caregivers confirm their awareness and knowledge of identifying and reporting hazards. The information related to potential hazards are set out in the information book given to all residents and family/whānau members. Monthly staff and management meetings have trended data and benchmarking results presented as part of the standing agenda. Meetings are used to review corrective actions put in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The management team and staff understand their responsibilities related to mandatory reporting and essential notifications. This includes responsibilities related to reporting of pressure injuries stage 3 and above.</p> <p>The number of incidents are collated on a monthly basis. Samples of incident/accident forms and the trended data were reviewed. Any</p>

		<p>trends identified are notified and information fed back to the board, committee meetings, staff meetings and the coaching and mentoring sessions. The service identifies strategies put in place in response to incidents and accidents and these were documented on the actual individual incident forms and on the resident's care plan as required.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>All staff and contractors who require an annual practising certificate (APC) have these validated at employment and annually. A register is maintained of when APC and competency assessments are due. Copies of APCs were sighted for all staff who require them.</p> <p>Staff files provided evidence that appropriate processes are implemented for the recruitment, employment and orientation of new staff. The volunteers go through a similar engagement process to the employed staff. There is at least annual performance reviews for the staff, with staff reviews based on the New Zealand Nursing Council core competencies. Where training or shortfalls in staff performance or achievement of goals/outcomes are identified, there are additional mentoring, support and coaching sessions implemented to assist staff achieve their desired outcomes throughout the year. The volunteers are provided with feedback annually, though a less formal process than the employed staff. The orientation, induction and ongoing education has undergone review, with the services gaining positive outcomes from these reviews (refer to 1.2.7.4 and 1.2.7.5).</p> <p>The service providers support and facilitate training and education that is appropriate to the needs of the service and maintain records of the training provided. Training needs are identified in the annual performance appraisal process, through review of monthly quality data and staff mentoring and coaching sessions. Mandatory training to meet contractual obligations is two yearly, or more frequently for such topics as infection control and restraint minimisation and safe practice. The care staff, activities, kitchen and housekeeping staff are supported to gain appropriate national qualifications if they do not already have them. The education schedule was reviewed for 2015 and the upcoming 2016 year has content and variety and meets all obligations of the provider's residential care contract with the district health board.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing levels are based on the safe indicators for aged care and dementia care. The general manager reports that the allocation and skill mix of the staff is reviewed weekly to ensure the minimum staffing levels are achieved. The current roster sighted for the rest home, hospital and dementia unit indicated a surplus of RN and caregiver hours. There is an additional one non clinical shift per week for each of the RNs to focus on their area of responsibility, assessment, care planning and mentoring and coaching of the caregivers.</p> <p>A review of four weeks of rosters identified that both the dementia unit and the rest home/hospital wings are staffed to ensure there is a skill mix and sufficient numbers of staff to meet residents' needs. All sick leave and annual leave is shown and replacement staff noted. There are sufficient numbers of laundry, housekeeping, activities, support and administration staff. All staff who have worked in the dementia unit for longer than six months have completed the dementia unit standards, with newer staff enrolled in the programme and on target to complete within six months to one year of employment. There are activities staff who have completed specialist education and training in dementia care. The RNs have completed their required interRAI training and demonstrated knowledge on the use of this tool to assess resident's needs to inform the care planning process.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made each shift which records the staff member's name and designation. The residents' files reviewed evidence that all records pertaining to individual residents are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic assessment/care plans printed and a copy placed in the resident's hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records. All residents' files reviewed showed evidence of completed interRAI assessments.</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>An 'Admissions Policy' was sighted and includes the procedure to be followed when a resident is admitted to the home. The New Zealand Aged Care Association (NZACA) standard Resident's Services Agreement is provided. Entry screening processes are documented and communicated to the resident and their family to ensure the service is able to meet the needs of the resident.</p> <p>The residents and family reported on interview the admission agreement was discussed with them prior to admission and all aspects are understood.</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>There is a specific transfer form to document information involving the resident to the DHB or other facility. The form highlights any known risks, such as falls, includes current medications, current information related to the national health index number (NHI), date of birth (DOB), next of kin, instruction regarding specific treatments and may include a medical referral as appropriate. When the resident is transferring to another facility another form is used outlining activities of daily living, reason for transfer, current medical problems, past history, medications, current treatments and observations. A verbal handover is given by the CM or RN on duty. Communication is maintained with the family as confirmed on interview.</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 medications is also noted. Where a resident refuses medications this is documented and communicated. Errors are required to be reported via the incident reporting system. The management of controlled drugs includes weekly checks of balance and six monthly quantity stock count. Residents can be assessed as safe to self-administer medications. The assessments are repeated on at least a three monthly basis.</p> <p>The facility uses the blister pack medicine system whereby medicines are delivered monthly except for 'PRN' (pro re nata – as required) medication which are delivered as required. When the blister pack medicines are delivered they are checked by the RN and evidence</p>

		<p>was seen of this on the signing sheet.</p> <p>The facility is working with the pharmacy to ensure the reduction of pharmacy errors following the use of a dispensing machine. There has been no resident administering errors as checks by the RN on delivery have eliminated the error.</p> <p>There is evidence in files reviewed that medication charts are reviewed three monthly by the GP or as required.</p> <p>Standing orders are not used at this facility.</p> <p>The RN reports that the GP works with the pharmacy but she is responsible for all medicines administered to residents. If medicine is brought in by family this is approved by the GP and is charted on the medication sheet.</p> <p>The RNs and competent caregivers are responsible for all medication rounds. Evidence was seen of the designated staff having up to date competency for medicine management and administering medicines. Lunchtime medication rounds were observed on both days of the audit and complied with standard requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food services manual identifies a dietary assessment is conducted when a resident is admitted to identify any dietary needs and food preferences. The policy details the principals of food safety, ordering, storage, cooking, reheating and food handling. Staff infection prevention and control requirements are also detailed. Guidance is provided on pureed diets, soft diets, diabetic diets, light diet, reducing diet and a normal diet. Portion sizes are included as well as practices to ensure residents remain appropriately hydrated. Practices to clean the kitchen and associated equipment is included.</p> <p>Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence was seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans. Residents reported that they are satisfied with the food services and given choice of foods to cater for dislikes and preferences.</p> <p>The service is managed by two cooks over seven days. There was</p>

		evidence of meal planning, cleaning routine and audit requirements being completed. All cooks are up to date with their food safety certificates and attend annual update education on infection control and first aid. The cook reported that she is supported by management with food supplies and understands the individual requirements of the residents.
<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 GM reported that the needs assessment team at the local DHB usually ring and a telephone discussion verifies the suitability for admission before the family visits, if the resident is in hospital. There is a folder which contains documentation of all enquiries and the action taken if the admission is declined. This included contacting the referral agency.</p> <p>The GM reported on interview that as three levels of care are available it is unlikely that an admission would be declined except for the availability of a bed.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial nursing assessment includes good use of clinical tools, and these include falls risk, pressure area, and pain assessment. Referral letters are sighted from external agencies, including DHB clinics, and there is evidence of family involvement in the assessment process. Evidence was sighted in files reviewed that assessments are conducted within the specified timeframes. In files reviewed, the assessment information was used as part of care plan development.</p> <p>The CM and RN reported that they oversee all care plans and residents and family are included.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>In all files reviewed evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and pain management.</p> <p>All health professionals document in the resident's individual clinical file and have access to care plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff</p>

		<p>reported they are informed of any changes to care plans at shift changeover.</p> <p>The CM or RN accompanies the doctor on his rounds and documents in the resident's notes at the end of the visit. The care plan is written in a language that is user friendly and able to be understood by all staff. In residents' files reviewed there was evidence to demonstrate involvement in care planning of the family.</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>	CI	<p>In the files reviewed there was documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated as required and timeframes to ensure residents' desired outcomes are being met. Evidence was seen in documentation of a resident whose falls risk assessment had changed from a low to medium risk. Changes to the care plans included regular checking of the resident, leaving the resident's bell accessible and use of a sensor mat.</p> <p>The clinical staff interviewed reported that they are informed of any care plan changes at the shift hand over and have relevant in-service education as required, specific to any new interventions.</p> <p>The programme used to improve residents care needs has identified outcomes are those identified on the initial interRAI assessment. Until this new programme was introduced there was not the accuracy in use of the original needs. Evidence is seen of any changes that occur and residents, staff and families are satisfied with the care.</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>	CI	<p>There is a lifestyle manager and activities coordinator employed at the facility. Both work full time and activities are available in the weekends as the care staff undertake activities during the hours when the activity staff are not on site.</p> <p>The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the diversional therapist and activities coordinator reported they are in the process of reviewing the programme to ensure that all residents have access. This includes reviewing the times and area of the facility that the activity is held.</p> <p>External visits for the residents include parks and van trips. The</p>

		<p>residents reported that the activities are positive and include exercise and music. Favourite activities are reported to be the visits of animals, day cares, schools and entertainment.</p> <p>The lifestyle care plan is completed and reviewed six monthly. Evidence was seen of monthly residents' meetings and annual resident satisfaction surveys.</p> <p>Improvements have been made to the documentation to support data collected ensures a multidisciplinary input to assessment.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Individual short term care plans are seen for wound care, infections and weight loss. These are kept in the resident's folder and during each shift documentation is made in the file as required. These are transferred to progress notes when completed or transferred to the long term care plan.</p> <p>Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in files reviewed. Progress notes are signed each duty by care staff or the RN in all levels of care. Evidence was seen of the family involvement in the care reviews. In files reviewed there was evidence of documentation if an event occurred that was different from expected and required changes to service. The residents and family members interviewed reported that they are given the opportunity to be involved in all aspects of care and reviews.</p> <p>The clinical staff interviewed have knowledge of the care plan documentation requirements.</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 policy related to exit, transfer or transition states that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes and in the diary. The family will be notified of the upcoming appointment and will be invited to attend and assist.</p> <p>In residents' files reviewed required referrals to other health services. Information relating to the referral process was sighted in residents' files.</p>

		Residents are given a choice of GP when they are admitted. Most residents use the GP contracted to the facility. If the need for other services are indicated or requested, the GP or CM sends a referral to seek specialist assistance from the DHB. The resident and the family are kept informed of the referral process.
<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>The cleaning, laundry and sluice room have safe, secure and appropriate storage of waste, chemicals and hazardous substances. Personal protective equipment (PPE), such as gloves, disposable gowns, sleeves and eye protection is available in the laundry/chemical storage area. The cleaning and laundry staff demonstrated knowledge on the safe use of the chemicals and PPE. Staff have ongoing education on infection prevention and control and the use of chemicals.</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 service has a current building warrant of fitness displayed.</p> <p>Hot water temperatures are monitored with the recordings within safe guidelines. Medical equipment has had annual calibration and electrical equipment is test and tagged. There has been a monthly compliance check of the environment.</p> <p>The environment promotes safe mobility, with secure hand rails in the hallways and floor surfaces that are intact and do not present a trip hazard. Each wing has access to the external areas. The dementia unit external area is separated from the rest home/hospital sections of the service. There is covered seating areas off each of the wings.</p> <p>The residents and families reported satisfaction with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>One wing has full ensuite facilities for all rooms. The rest of the wings have adequate numbers of shower, bathing and toilet facilities. There are at least two toilets and two showers in each corridor, with one wing having a disability access bathroom that can fit the bath bed. All of these facilities have privacy locks and signage. The residents and families reported satisfaction with the facilities at the service.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas</p>	FA	<p>Most rooms are single occupancy and suited to the needs of residents requiring rest home, hospital or dementia level of care. The rest home/hospital wings are separated from the specialist dementia</p>

<p>appropriate to the consumer group and setting.</p>		<p>unit. The service has one wing that is all hospital level of care and three wings that are dual purpose (mix of rest home and hospital level of care). One wing is a specialised secure dementia unit. Each resident's room has their personal items and provides enough space for the resident and staff to mobilise. The residents and families reported satisfaction with the personal space and the individualised care that meets the resident's needs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Each of the wings has lounge and dining areas. There is also a central dining area, entertainment room and library. The dementia unit is separated from the rest home/hospital wings. Residents' rooms also provide areas for residents to relax or entertain in privacy. The residents and families reported satisfaction with the access to dining and lounge facilities</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The cleaning and laundry is conducted by specific cleaning and housekeeping staff. The linen laundering is conducted by an offsite laundry service. The laundry has a dirty to clean flow, with processes implemented for infection prevention and control. Chemicals, laundry and cleaning equipment are securely and hygienically stored. The external chemical supplier conducts monthly reports on the effectiveness of the cleaning and laundry chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The approved evacuation scheme is dated 2008. The fire and emergency equipment has a monthly inspection as well as an annual certification by an external contractor. Emergency and security training is provided as part of staff orientation and ongoing in-service education. Evacuation drills are conducted six monthly, with the last conducted on November 2015. Staff demonstrated knowledge on how to respond in emergency or civil defence situations.</p> <p>The service has bottled gas for cooking and emergency lighting in the event of mains failure. There are water tanks and bottled drinking water that is accessible in emergency situations.</p> <p>Each room, toilet and bathing facility has access to a call bell. The call bell system has a light and audible alert when activated. The residents and families reported satisfaction with the time frames in which call bells are answered.</p>

		<p>The layout of the dementia unit allows for residents with cognitive impairment to wander freely inside and into the secured external area.</p> <p>There are processes and checklists conducted to ensure the entrances, doors and windows are secure. After hours visitors are required to use the doorbell to gain access to the facility. Staff, residents and families report satisfaction with the security arrangements.</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 areas used by residents and families are ventilated and heated. Each resident's room and hallway have wall mounted radiators and at least one window. One wing has underfloor heating. The residents and family report satisfaction with the heating, light and ventilation.</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 role of the infection prevention and control coordinator and the responsibilities are identified in the infection control manual. The IPCC (Infection Prevention Control Coordinator) is responsible for facilitating the infection prevention and control programme. The RNs and care staff interviewed confirmed timely ongoing communication is occurring when residents are suspected or confirmed as having an infection. This includes at shift handovers and discussion at monthly staff meetings.</p> <p>Evidence is seen of attendance at in service education relating to infection control and audits which are undertaken as part of the programme.</p> <p>An annual review of progress towards achieving the infection prevention and control objectives has been undertaken by the IPCC in 2015. All objectives have been met and there is a process for any areas that may to be actioned for improvement.</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>	FA	<p>The IPCC confirmed being responsible for facilitating infection prevention and control activities. The IPCC has attended relevant education on infection prevention and control. The IPCC advises she liaises with the GP if there are any concerns about a resident with a known or suspected infection.</p> <p>The IPCC is responsible for gaining infection control, infectious</p>

		disease and microbiological advice and support, where this is not available within the organisation. In the event of an outbreak advice will be sought from GP, gerontology nurse specialist at the DHB or laboratory services.
<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>	FA	<p>The infection control manual contains the policies and procedures required to meet this standard.</p> <p>A copy of the infection prevention and control policies are available for staff to refer to as and when required and this was sighted. Staff interviewed confirmed access to policies on infection prevention and control. Staff reported if they had any concerns they would contact the CM who is on call when not on site. The GP confirmed in interview that he is contacted by staff in a timely manner when the needs of the resident have changed.</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>	FA	<p>Education is provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. In addition newsletters issued by an external infection control company and the DHB include infection prevention and control topics.</p> <p>Residents and family are provided with advice on infection prevention and control activities via residents' meetings. The residents' meeting minutes included discussion on the importance of hand hygiene.</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>	FA	<p>The infection control programme includes documented definitions of infections. The surveillance method is also defined and suspected infections are reported on a template form. There is a monthly analysis of infections. An external company analyses results and reports are available to the facility.</p> <p>Surveillance for residents with infections is occurring. Staff interviewed reported they are responsible for advising the RN if they are concerned a resident has an infection. The staff interviewed were able to identify the common signs and symptoms of infections.</p> <p>There has been a recent outbreak of scabies and the systems are in place to ensure correct management of the outbreak.</p> <p>A review of the applicable residents' notes verified short term care plans were developed as required for residents with infections and</p>

		that infections are being appropriately reported.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is no recorded use of restraint since the last audit. All documentation, including assessment, approval processes and actions to be taken, are clearly set out should restraint be required. Policy shows that enablers are voluntary and that the least restrictive option would be used with the intention of promoting or maintaining resident independence and safety, such as a chair lap belt to prevent falls, or bedside rails to help the resident feel safe. The policies for restraint and enabler use are part of the orientation and induction training as well as in the ongoing in-service education programme. Consent is gained to evidence that enabler use is voluntary.</p> <p>The specialist dementia unit focuses on the promotion of quality of life that minimises the need for restrictive practices through the management of challenging behaviours. The internal and external space in the dementia unit allows maximum freedom of movement while promoting the safety of residents who are likely to wander.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	CI	<p>Monthly surveillance is collated, benchmarked and reviewed by the management team. Benchmarking occurs with internal, national and organisational targets. Data is trended and results presented at staff and management meetings. The service has set key performance indicators that are linked to the business plan, strategic directions and organisation's foci. The general manager reports to the Board on how the service is performing in the key components of service delivery. The reports reviewed indicated that the service is making ongoing improvements through benchmarking and key performance indicators. This evidence is also linked to 1.2.3.6.</p> <p>Monthly coaching and mentoring sessions with the registered nurses are conducted, with review of specific data, results and trends related to each</p>	<p>Having fully attained this criterion the service can in addition clearly demonstrate that a thorough the review process, which includes analysis, benchmarking and reporting of findings, has resulted in quality improvements to the service provision and residents' safety and satisfaction.</p>

		RN's primary care residents. Strategies are then implemented to make any improvements in care, procedures or processes. A number of the coaching, mentoring records and the RNs' journals evidence reflection of any opportunities to make improvements and the actions and follow up to ensure these improvements have achieved the desired outcomes.	
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The service has conducted a number of quality improvement projects in 2015 and which continue to date in 2016. Some of the projects sampled are related to the strategic direction, analysing performance, education and coaching and mentoring for staff. Resident satisfaction is measured as part of the review, which includes resident and family satisfaction and achievements against benchmarking and organisational targets. The reporting of the analysis and outcomes of the project are presented to the Board of Trustees, quality meetings, staff meetings and residents meetings.</p>	<p>The achievement of the quality projects and quality management systems is rated beyond the expected full attainment. The quality improvement projects sighted have a documented review process which includes analysis and reporting of findings to management, the board of trustees, staff and residents. The projects documentation evidences action taken based on findings and improvement to service provision. Resident safety and/or satisfaction have been measured as a result of the review process.</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	CI	<p>All new staff undertake an orientation and induction that includes the essential components of service delivery and health and safety. Kamo Home and Village has conducted a project and review of the orientation and induction processes. The review indicated that there were gaps in achieving the organisational targets related to the orientation and induction process. Staff expressed that they were not always confident with some aspects of their work and unsure of appraisal requirements. To assist in the improvements, the management team mapped the orientation</p>	<p>The achievement of the quality improvement projects in the orientation and induction processes are rated beyond the expected full attainment. With these projects there has been a documented review process which includes the analysis and reporting of findings to staff, management and the board. The projects include documenting actions to make improvements in meeting targets and compliance with the orientation and induction, increase staff knowledge, confidence and skill in care of the residents. Positive outcomes have been measured in reduction of manual handling</p>

		<p>process to ensure the orientation and induction was meeting requirements. Introduction of quality checks/internal audits for the orientation, induction and coaching and mentoring processes were applied. The outcomes achieved have resulted in improved staff competencies, improvements in training attendance and has resulted in improved outcomes, such as a reduction of manual handling incidents.</p>	<p>incidents and increase in staff, resident and relative satisfaction.</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>CI</p>	<p>The service has conducted a quality improvement project related to their education, training and mentoring programmes. The process of mapping of the human resources process and the focus of the requirements of human resources for the strategic and business planning saw changes implemented to create a coaching and mentoring approach in the structured education programme. The project included a review of what the opportunity for improvement was, the review process and how this was measured, the actions implemented and what benefits and desired outcomes were achieved. With the quality improvement project into the education programme, the organisation measured that there was an increase in staff obtaining their national qualifications, improved training attendance and positive feedback in observed performance. The analysis records an increase in staff knowledge and confidence. Monthly meetings were structured with registered nurses for clinical feedback and one to one coaching sessions. There has been an increase in the service meeting care outcomes and key performance that is aligned with the strategic focus.</p>	<p>The achievement of the quality improvement projects in ongoing education and the coaching and mentoring programmes are rated beyond the expected full attainment. With these projects there has been a documented review process which includes the analysis and reporting of findings. The projects include documenting actions to make improvements in the education programme, increase staff knowledge, and confidence and skill in caring for the resident's. Positive outcomes have been measured in staff, resident and relative satisfaction.</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>CI</p>	<p>Following the introduction of the interRAI assessment it became apparent that the CAPS on the interRAI needed to be traced to the formal in house care plan. The document was drafted, reviewed, trialled, and is now operational. Evidence was sighted of this in the care files reviewed. This resulted in aligned care planning and quality checks of the care plan. RN and staff interviewed have knowledge of the new system and enjoy working with it.</p>	<p>Following the introduction of the InterRAI assessment it became apparent that the CAPS on the interRAI needed to be traced to the formal in house care plan. The document was drafted, reviewed, trialled and is now operational. Evidence is sighted of this in the care files reviewed. This resulted in improved aligned care planning and quality checks of the care plan. RN and staff interviewed have knowledge of the new system and enjoy working with it.</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>With the review of care planning alignment to interRAI it was also noted an improved process to determine the activities that support the health and wellbeing of the resident. Forms were improved to include the physiotherapist, manicurist and hairdresser. The planning has a process map to collect data from the life style planning and wellbeing assessments which are necessary for clinical planning.</p>	<p>With the review of care planning alignment to interRAI it was also noted an improved process to determine the activities that support the health and wellbeing of the resident. Forms were improved to include the physiotherapist, manicurist and hairdresser. The planning has a process map to collect data from the Life style planning and wellbeing assessments which are necessary for clinical planning.</p> <p>The residents and families interview reported that they feel more involved in the activities of their choice. This includes comments from allied health providers.</p>

End of the report.