

Kumeu Village Aged Care Limited - Kumeu Village

Introduction

This report records the results of a Surveillance 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 - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 July 2017 End date: 18 July 2017
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:	81

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

Kumeu Village Retirement Home provides rest home, hospital and dementia (memory assist) level care for up to 83 residents. The service is operated by the owner/manager and is supported by a clinical manager. Residents and families spoke positively about the care provided.

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

The audit identified areas requiring improvement relating to the food service, medication management and interRAI assessme. Three of four areas identified as requiring improvement at the previous audit have been fully addressed and one remains open.

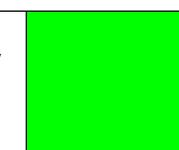
Consumer rights

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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There are adequate communication systems to ensure effective communication between staff, residents and their families and with other health providers. There is an interpreter policy and processes are in place to access interpreting service if and when needed.

The service has a documented complaints management process which is implemented. There is only one outstanding complaint at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation has a documented quality plan for 2017 to 2018. Objectives are clearly set out along with the scope, direction, goals, values and mission statement of the organisation. The strategic planning covers all aspects of service provision to meet the needs of residents. The service has implemented five of 10 principles of the Eden philosophy There and these are well embedded into the organisation.

The quality and risk plan and systems in place fully optimises and supports safe service delivery. Systems are in place for monitoring the services provided. Data is trended against previously collected data to show how the set objectives are being met. Quality and risk management activities and results are shared with staff, residents and family/whanau as appropriate and are reviewed monthly by the directors. Corrective action plans are being developed, implemented, monitored and signed off. Any actual and/or potential risks are identified and mitigated and the hazard register is up-to-date.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. Orientation is provided to all newly employed staff and a staff training programme ensures staff are competent to undertake their role. Staff are supported to undertake post graduate study relevant to their role.

Staffing levels and skill mix more than meet contractual requirements, the Eden alternative principles, and the changing needs of residents.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

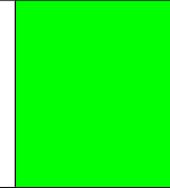
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are administered by staff who are competent to do so.

The food service meets the nutritional likes and dislikes of the residents with special needs catered for. Residents verified satisfaction with meals.

Safe and appropriate environment

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

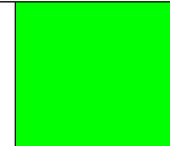


Standards applicable to this service fully attained.

The building warrant of fitness is current and is publicly displayed at the entrance to the facility.

Restraint minimisation and safe practice

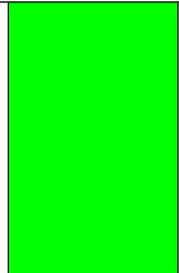
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Enablers are described as voluntary. Staff interviewed are well informed and education is provided at orientation and is ongoing annually. At the time of audit there were three enablers in use to allow residents to maintain their independence and four residents using a restraint.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. Outbreak management is undertaken to meet legislative and reporting requirements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	1	2	0	0
Criteria	0	39	0	2	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information in a number of areas in the facility.</p> <p>The complaints register reviewed had only one complaint that had not been closed out. The last correspondence is dated 17 June 2017. The service provider is awaiting a policy to be reviewed by the DHB and closure by the DHB if the policy is accepted. Previous complaints received had been dealt with appropriately with actions taken, through to an agreed resolution, are clearly documented and completed within specified timeframes in the Code. Action plans reviewed show any required follow-up and improvements have been made where possible.</p> <p>The manager is responsible for the complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative`s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents` records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the DHB when required. Staff knew how to do so, although</p>

conducive to effective communication.		reported this was rarely required due to staff being able to provide interpretation as and when needed and the use of family members.
<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 strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. The strategic plan and operational goals for the organisation are dated 2016 / 2018. A sample of reports reviewed showed adequate information to monitor performance is reported including any emerging risks or issues. The service has a mission statement and home philosophy and vision 'To embrace the philosophies of the Eden Alternative to help ensure the residents are living in human habitat that encourages continued growth and purpose'.</p> <p>The service is managed by a manager who is an owner director. The manager holds relevant qualifications and has worked in aged residential care for 20 years. The manager has completed higher level business study equivalent to Masters of Business Administration. Short course training such as 'dementia beyond drugs' (Eden training) was completed. The manager is suitably skilled and experienced for this role and has responsibilities and accountabilities defined in a job description and the individual employment agreement. The manager confirms knowledge of the aged care sector, regulatory and reporting requirements and maintains currency through ongoing education. The manager is supported by the operations manager, the quality manager, the clinical manager and the administration manager. In addition, support is provided by the registered nurses who meet regularly monthly.</p> <p>The service holds contracts with the DHB for rest home, hospital, dementia care (memory assist), respite care and long-term support – health conditions. On the day of the audit there are 81 residents in total, including 14 rest home level residents, 47 hospital level and 20 dementia care (memory assist) residents. There are currently no residents receiving respite care or long term support for chronic conditions.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	FA	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of accidents and incidents, complaints, audit activities, a regular resident satisfaction survey, monitoring of outcome, clinical incidents including infections and restraint minimisation.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters.</p> <p>Regular review and analysis of quality indicators occurs and related information reported is discussed at the clinical governance meetings. A print out of clinical indicators is posted on the staff notice board and discussed at the staff meeting held every six weeks. Minutes reviewed included discussion on pressure injuries, restraints,</p>

improvement principles.		<p>falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through assisting with internal audits.</p> <p>Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvements is occurring. Resident and family surveys are completed annually. The last survey showed evidence of resident and family satisfaction with all aspects of service delivery.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of any obsolete documents. Staff are updated on new policies or changes to policies through a consultation process and at staff meetings.</p> <p>The manager described the processes for identification, monitoring and reporting any risk and development of mitigation strategies. The risk register show consistent review and updating of any risks, risk plans and the addition of new risks. The manager is aware of and has attended training in the Health and Safety at Work Act (2015) requirements and has implemented these new requirements.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed up in a timely manner. Adverse event data is collated, analysed and reported to the governance meeting and meeting minutes reviewed showed discussion in relation to trends, action plans and improvements made. Any trends are separated for rest home, hospital and memory loss.</p> <p>Policy and procedures described essential notification reporting requirements such as pressure injuries, health and safety, human resources, infection prevention and control or any coroner or DHB requirements. The manager advised there have been no notifications of any significant events made to the Ministry of Health since the previous audit.</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</p>	FA	<p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resource management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support through their initial orientation period. Staff</p>

<p>requirements of legislation.</p>		<p>records reviewed show documentation of completed orientation and a performance review is performed annually.</p> <p>Continuing education is planned annually. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff working in the memory assist house, have either completed or are enrolled in the required education. Education records reviewed demonstrated completion of the required training. Training is provided in the Eden Alternative philosophy for all staff. Staff interviewed stated they were offered educational opportunities from tertiary level education to attending forums and/or seminars. The registered nurses reported that the annual performance appraisal process provides an opportunity to discuss individual training needs and review of competencies. Appraisals were current for all staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents, supported by the use of a workload measurement tool. The shifts are well covered and registered nurses are available on every shift 24 hours a day, seven days a week. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff were available and that they were able to complete their work allocated to them. Team work is encouraged. This was further supported by residents and family interviewed. Observation and review of a four-week roster cycle sample during the audit confirmed adequate staff cover has been provided. The organisation has some casual staff for short notice roster gaps. The registered nurses are trained in first aid.</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' details and National Health Index (NHI) numbers are used as the unique identifier on all residents' information reviewed. Clinical records were legible with the name and designation of the person making the entry identifiable. Archived and current records were stored appropriately and no personal or private resident information was on public display during the audit. The area identified for improvement from the previous audit has been closed out.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request with a formal medication reconciliation undertaken six-monthly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Imprest stock medication is not managed to meet the requirements of safe medication standards/guidelines.</p> <p>There are no residents who self-administer medications at the time of audit. Policy identifies appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided on site by three cooks and a team of kitchen hands and is in line with recognised nutritional guidelines for older people. The menu follows a three-week rotation displayed in the kitchen and on notice boards. The menu has been reviewed by a qualified dietitian in November 2015, however it is not always followed. Two cooks were interviewed; one has a diploma qualification in food services whilst the other has 30 years of experience in the industry. The two cooks interviewed show evidence of compliance with infection control practices during the recent gastrointestinal outbreak (May 2017).</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, however there is evidence of aspects of food storage not compliant with legislation and guidelines. The service is in the process of compiling information for application of an approved food safety plan and registration. The fridge, chiller and deep freezers are closely monitored; however, this is not consistent.</p> <p>A nutritional assessment is undertaken on admission by a registered nurse to identify the resident's food preferences, likes, dislikes and allergies and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily</p>

		<p>meal plan. The cook maintains a folder of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times.</p> <p>Nursing staff record weight on the monitoring chart which is reviewed by the quality coordinator and discussed with the GP and dietician. When a resident has weight loss or is at risk of malnutrition they are referred to the dietician for input as evidenced in the resident's records.</p> <p>Residents and family members interviewed were satisfied with the meals. Residents report feedback on food services both verbally to the cooks and at the monthly residents' meetings. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>Information is documented using both electronic interRAI and paper based nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, behaviour management and memory loss, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Not all residents have a current interRAI assessments completed. Residents and families confirmed their involvement in the assessment process. This was also a finding in the previous audit and has yet to be fully resolved.</p> <p>All residents were placed in the appropriate area for their designated level of care as per their NASC assessments. This was an issue in the previous audit and is fully resolved.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner and care is appropriate to meet residents' needs. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer,</p>	<p>FA</p>	<p>The activities programme is provided by a full time trained diversional therapist holding the national Certificate in Diversional Therapy, a full-time activity coordinator, a part time assistant and volunteers who work in the rest home, hospital and memory assist centre (dementia service) providing a seven-day cover. The lifestyle programme extends over the twenty-four-hour period for the memory assist centre. The church services and physical activity programmes are some of the examples of opportunities for integration of residents in the</p>

<p>activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>memory assist centre with those in the rest home and hospital level.</p> <p>Kumeu Village Retirement Home is progressing on the Eden journey having achieved 5 (of 10) Eden principles and are working towards achieving the remaining Eden principles and becoming a fully “Edenized” home. Eden philosophy underpins projects and initiatives the service develops.</p> <p>A social assessment and history is undertaken on admission to ascertain resident’s needs, interests, abilities and social requirements. This is captured on the ‘my life map’, which is displayed in the front of the resident’s records. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>There is a full and varied activities programme in place which incorporates the physical, psychological, mental and spiritual aspects as evidenced by the lifestyle calendar displayed on the notice board. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. Outings for the residents are arranged on a regular basis to maintain community connections.</p> <p>The monthly residents’ meeting minutes sighted showed resident’s input and evaluation of the effectiveness of the activities programme and opportunities for new ideas. Residents and families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met.</p> <p>Daily activities attendance records are maintained for all residents and are reviewed by the diversional therapist and activity coordinators to assess the interest of the residents.</p> <p>Activity staff keep up to date with current best practice by attending the diversional therapy conference and training at least six-monthly with other providers.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided detailed examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>A current building warrant of fitness expires 20 February 2018. The certificate is publicly displayed at the entrance to the facility. There have been no alterations to the existing building since the previous audit.</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The infection prevention control (IPC) coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Short term care plans were evidenced in the files reviewed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager/quality and IPC committee. Data is benchmarked externally against other aged care providers.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice. Staff verbalised their understanding in relation to safe outbreak management. Evidence of reporting was sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated understanding of the organisation's policies, procedures and practice, the role and responsibilities involved. Training is provided annually.</p> <p>On the day of the audit, four residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of restraint approval group meeting minutes dated 14 June 2017 and files reviewed of those residents who have approved restraints and from interview with staff. The two areas identified for improvement from the previous audit have been closed out.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The policies and procedures covers environmental restraint and all appropriate assessments are performed by the registered nurse and discussed with the approval group. A full history of the resident is considered before initiating any form of restraint. Any risks identified are included in the care planning process. This was an area identified for improvement at the previous audit and has been effectively closed out.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Restraint is only used as a last resort to maintain safety of residents, service providers or others. Staff in the memory assist unit are fully informed about restraint monitoring and the appropriate form utilised by the service. Education is provided as part of the staff training programme and this was reviewed. This was an area of improvement identified in the previous audit that has been closed out.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with</p>	<p>PA</p> <p>Moderate</p>	<p>Safe and appropriate prescribing, administration, review, and medicine reconciliation processes occur. The service uses an electronic medication system with a two-monthly review undertaken as part of the internal audit system. The administration rounds viewed were performed in a safe manner.</p> <p>Three bottles of antibiotics and one box of paracetamol suppositories in the medication cupboard had a residents' names crossed off and the word imprest handwritten on them. The four residents' whose names had been crossed off were no longer at the facility. Not all medication is being returned to the pharmacy when it is no longer required or when the resident leaves the facility.</p>	<p>Three bottles of antibiotics and one box of paracetamol suppositories in the medication cupboard had the residents' names crossed off and the word imprest handwritten on them. The residents' whose names had been crossed off were no longer at</p>	<p>Ensure that all aspects of safe medicines management are followed in relation to the imprest system and disposal and return of medications to the pharmacy.</p>

legislation, protocols, and guidelines.			the facility.	30 days
<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>	PA Low	<p>There is a registered dietician approved menu for aged care which was reviewed in November 2015. This is a three-week rotating menu. The approved menu is not always adhered to and staff do not record when there are variances to the menu. At the time of audit, the cooks interviewed stated they do not always follow the menu nor do they always order food to ensure the menu can be followed.</p> <p>The nutritional assessment undertaken for each resident clearly reflects their food and fluid requirements, including special diets, which can be catered for by the service. Residents and family members confirmed that alternative choices are offered for each meal to meet residents' likes and dislikes.</p>	<p>On the day of the audit the food served for the mid-day meal was not in line with what was written on the menu. No documented evidence is kept when a menu change is made.</p>	<p>Provide evidence that food, fluids and nutritional needs for the residents are provided in line with dietitian approved menu and any variance is documented.</p> <p>180 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>The food service manual is in place and identifies the policies and procedures. The policy details the principals of food safety, ordering, storage, cooking, reheating, waste management and food handling. However, fridge temperature monitoring as well as corrective actions for temperature readings outside the normal range is not consistently occurring. There is an allocated staff member who undertakes the fridge temperature recording and when they were on leave for a 10-day period the temperatures were only taken twice. There is a cooler unit which operates in the shop area of the foyer and at the time of audit it was recording a 12.8oC reading. Prior to turning up the temperature of the cooling it was freezing the food. The administration staff stated they had contacted the supplier of the new cooler unit and were waiting for them to arrive. Food was removed from the unit during the audit.</p> <p>Dry foods in the pantry are decanted, dated and sealed. Not all frozen foods are clearly labelled or dated. For example, left over pieces of frozen fish were</p>	<p>Fridge/freezer temperature monitoring is not consistently occurring. When it was known that the cooler in the shop was not operating at optimal temperature staff continued to use it.</p> <p>Not all frozen food is dated or labelled.</p>	<p>Provide evidence that all aspects of safe food management legislation and guidelines are met.</p> <p>180 days</p>

		found wrapped but not dated and not all meat was labelled or dated.		
<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</p> <p>Moderate</p>	<p>The needs, outcomes and goals of residents are identified via the assessment process and are documented to form the service delivery care plan. Paper based assessments are still used for residents who have not been interRAI assessed. There are three RNs who are interRAI trained but only two undertake the assessment process. Not all residents have an interRAI assessment and this is an ongoing issue which is being monitored by the District Health Board. There are two more RNs booked on the August 2017 interRAI training course.</p>	<p>At the time of audit only 66.25% of residents are interRAI assessed. The overdue assessments range from 10 days to 475 days.</p>	<p>Provide evidence that all interRAI assessments are completed and up to date.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.