

Kamo Home & Village Charitable Trust - Kamo Home and 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: Kamo Home & 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: 7 May 2018 End date: 8 May 2018

Proposed changes to current services (if any): The service has increased the available bed numbers by one bed for the care of residents requiring end of life care.

The ten bed studio apartments have been reviewed and verified as appropriate for the purpose of providing both rest home and hospital level care (i.e. have changed to dual purpose beds). One of the studio apartments has two residents residing. This apartment is of suitable size for two residents.

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

General overview of the audit

Kamo Home and Village is one of three aged related residential care facilities owned and operated by Kamo Home and Village Charitable Trust. Kamo Home and Village provides private hospital, rest home, and dementia level care for up to 71 residents. There were 66 residents receiving care on the first day of this audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, a review of residents' and staff files, observations, and interviews with residents, family members, managers, staff, the chairman of the board of trustees, and a general practitioner.

At the last audit there were no shortfalls identified. There are eleven new areas identified for improvement from this audit related to linking the use of restraint to the quality and risk programme, corrective action processes following incidents / episodes of challenging behaviour, verifying registered health professionals have current annual practising certificates, and having a 24-hour care plan for residents receiving dementia level care. Ensuring all applicable staff have a current medicine competency, consistent assessment and safe storage of medicines for residents who self-administer medicines, safe food storage, and four areas related to ensuring the safe use of enablers and restraint are also areas requiring improvement.

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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The service demonstrates residents' rights to full and frank information and open disclosure principles are met. Independent interpreter services are accessible; however, are rarely required.

Complaints management is well documented. Complaints are investigated and responded to in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation's philosophy, mission and strategic intent statement are identified in the business, quality and risk plan. Significant changes have occurred since the last audit in developing and implementing a new management structure and associated systems and processes to operate all three aged related care facilities owned by Kamo Home and Village Charitable Trust, including Kamo Home and Village, into one organisation. The group general manager, and the other three members of the new management team work together, with the Kamo Home and Village clinical charge nurse to plan that services offered meet residents' needs, legislation and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, complaints management, incident/accident reporting, benchmarking (both nationally and with some Australian facilities), hazard management, and infection control data collection. Quality and risk management activities and results are shared with management, staff and the board of trustees.

New staff have an orientation. Staff participate in relevant ongoing education, which includes the opportunity to complete an industry approved qualification. The service has a documented rationale for staffing which is implemented. There is always at least one registered nurse on duty, and normally more in the morning and afternoon shifts.

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 service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that meet the needs of the residents.

Residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A medicine administration system was observed at the time of audit.

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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The facility has a current building warrant of fitness. There have been no changes required to the fire evacuation plan. Regular fire drills are conducted. The new bedroom for the provision of end of life care is fit for purpose. The ten studio apartments are appropriate for providing both rest home and hospital level care, with one studio apartment suitable for two residents.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Policies and procedures are available to guide staff on the use of restraints and enablers. These documents are currently under review.

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.
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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported to staff and residents, where appropriate, in a timely manner.

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	10	0	3	6	0	0
Criteria	0	32	0	5	6	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>	<p>FA</p>	<p>Kamo Home and Village implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family and staff reported their understanding of the complaints process. Three family members reported they had brought aspects of care to the attention of staff. Two events (related to lost property) had been reported and verified to be followed up via the incident management system. Two residents report they sometimes wait for their call bell to be answered and call again if urgent, although noted they had no concerns about the care provided or staff. Formal complaint / compliment forms are present at the main entrance and include an area for the recording of complaints and compliments.</p> <p>A complaints register is maintained. One complaint via the District Health Board has been received since the last audit, and a separate DHB investigation related to pressure area prevention and management has been undertaken (refer to 1.2.4.3). There have been no complaints from the Ministry of Health or Health and Disability Commissioner since the last audit. A review of nine complaints verified that complaints are acknowledged, investigated and responded to appropriately in a timely manner. Staff interviewed confirmed they bring any resident or family member's concerns to the attention of the RNs.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The RN and group care manager confirmed the family and residents right to be informed. This is discussed with residents and family as part of the admission process.</p> <p>One resident is unable to communicate verbally. Staff have que cards and utilise body language to help with communication. Staff interviewed identified they can effectively communicate with the resident. Staff advise there are no residents who currently require an interpreter and note interpreters are rarely required. However, they can detail the process of accessing interpreters including the use of language line.</p> <p>All family members interviewed confirmed that they were kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this communication occurred.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Kamo Home and Village is one of three aged related care facilities owned and operated by Kamo Home and Village Charitable Trust (KHVCT). Significant governance changes have occurred since July/August 2017, with KHVCT developing and implementing a new governance / management structure. New roles have been developed titled group care manager, group business manager, and group support services manager. The personnel in these roles are responsible for developing and / or reviewing processes and systems to ensure they are current and fit for purpose across all three aged related residential care facilities owned. Specific roles and responsibilities are detailed in position descriptions and the reporting lines are also detailed in the organisation chart. Activities including (but not limited to) maintenance / facility management, human resources, quality and risk activities, clinical care systems and processes, and laundry services are overseen by the management team. Staff education is also facilitated at a group level. These roles (excluding educator) report to the group general manager, who was appointed to this role in July 2018, and is responsible to the Board of Trustees.</p> <p>The group general manager reports she is responsible for ensuring the day to day care needs of the residents are being met as required by the provider's contract with Northland District Health Board (NDHB), with the assistance of the clinical charge nurse (CCN). The group general manager was previously the general manager for Kamo Home and Village and is a registered nurse with a current annual practising certificate. She has held a senior management role at Kamo Home and Village for eight years and has attended more than eight hours of education relevant to</p>

		<p>managing an aged residential care service in the past 12 months.</p> <p>Kamo Home and Village Charitable Trust has a documented mission statement, philosophy and values that is focused around faith, and the provision of individualised, quality care. The group manager advised that some aspects are currently under review.</p> <p>The Board of Trustees (BOT), comprising seven members meets monthly. The meeting is also attended by the group general manager. The chairperson reports having regular meetings or other communications with the group general manager as applicable / required and is satisfied communication is timely and appropriate. Minutes of BOT meetings sighted included discussion on quality and risk, health and safety, future planning, human resources, business opportunities, and the continuum of care. A proposal for the restructure was developed that was subsequently reviewed and approved by the BOT. A more detailed plan related to the implementation was developed including timeframes, and who was responsible for the specified activities.</p> <p>The clinical charge nurse is an experienced aged care registered nurse with a current annual practising certificate. The CCN was appointed to the role in July 2017, and prior to this worked in this facility as a senior RN. The management team monitors the progress in achieving business goals, and resident care needs via day to day care / activities, resident / family feedback and monitoring of the results of quality and risk activities.</p> <p>The service has a contract with NDHB for the provision of aged related residential care at continuing care, rest home, and dementia level care. The service has offered the DHB a dedicated bed in the dementia unit for a defined period of time for respite services. An acknowledgment letter from the DHB notes this and advises 'funding will be on an adhoc basis'. There are eight rest home level residents, 34 hospital level residents and 24 dementia level residents at the time of audit. There are no boarders, or residents under the care of mental health services. Two residents are receiving respite services (hospital level care). One resident receiving hospital level care is aged under 65 years.</p> <p>A separate contract is in place for long term support chronic health conditions. There are three clients receiving services under this contract (at hospital level care).</p>
Standard 1.2.3: Quality And Risk Management Systems	PA Low	Kamo Home and Village has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, benchmarking, health and

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>safety reporting, hazard management, infection control data collection and management, and complaints / compliments management. The use of restraint is not currently linked to the quality and risk management programme.</p> <p>Regular internal audits are conducted, which cover relevant aspects of service including aspects of care, documentation and medicine management. This is via the quality and benchmarking programme with other New Zealand and Australian facilities. All three facilities owned by KHVCT are included in the benchmarking programme, and each facility results are distinguishable. Currently the Kamo Home and Village rest home resident outcome data / audits is being included with the Mountainview data (rest home level) to facilitate more meaningful denominator data. Benchmarking reports summarise where Kamo Home and Village features amongst the participating organisations. The national / international reports clearly detail any variation since the last audit (positive, negative or neutral). The most recent results (March 2018) demonstrated the service is above the benchmark for skin tears, total falls, and falls with no injuries for hospital and dementia level clients, and under the benchmark for pressure injuries and medicine errors. Infection data is also included in the benchmark programme.</p> <p>In addition, the number of falls and pressure injuries are benchmarked with other aged residential care facilities within Northland DHB. Quarterly reports are received that details Kamo Home and Village position for these two indicators. The report correlates the findings as detailed above but notes the pressure injury rate for hospital level residents is above the identified benchmark rate.</p> <p>A resident and family satisfaction survey has recently commenced again. This is the first formal survey completed since 2016.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation for events sighted; excluding incidents / accidents and challenging behaviour (refer to 1.2.4.3).</p> <p>Quality information is shared with all staff via shift handover as well as via the regular staff and managers' meetings. The minutes of staff meetings are made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations / policies.</p> <p>Meetings are held three monthly with residents to obtain resident feedback on the facility, services, food, and activities as well as obtain information for future planning. The minutes of the three meetings were sighted.</p>
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		<p>The CCN also has regular meetings with the team of registered nurses. This was verified by the RNs interviewed. Minutes of recent meetings were not available for review. The CCN was on leave at the time of audit.</p> <p>Policies and procedures were readily available for staff. Policies are reviewed at least every two years or sooner where required and are approved by the group general manager. Procedures are reviewed in response to changes in policy, or where necessary in response to incidents / accidents, or where processes / systems are identified as needing improvement. Process maps are maintained electronically. The current version of associated procedures and template forms are embedded in the process map to ensure the most current version of documents is available and used at the time. One paper copy of documents is available for staff. The group business services manager is responsible for document control processes. Policies and procedure are discussed during the staff education programme and at staff meetings where relevant.</p> <p>Staff, resident and family members interviewed were happy with the majority of the services provided at Kamo Home and Village or had noted they had discussed issues / concerns directly with staff at the time.</p> <p>Actual and potential hazards and risks are identified in the risk and hazard register. These contains potential and actual hazards and risks common for all three facilities owned and operated by KHVCT, as well as Kamo Home and Village specific hazards and risks. Mitigation strategies have been documented. The chair of the board of trustees is satisfied that new/emerging risks are brought to the attention of the board in a timely manner. Staff confirmed that they understood and implemented documented hazard identification processes. The health and safety representative detailed the processes for reviewing hazards. The health and safety representative has completed a two-day health and safety training programme (level 1) and the certificate of completion was sighted.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme. While applicable events are being reported, actions taken in response to incidents are not sufficiently detailed or monitored for effectiveness.</p> <p>The group general manager advised at least five essential notifications have been made by KHVCT in relation to services since the last audit. This included the death</p>

		<p>of a resident that was referred to the Coroner (November 2016). The group general manager advised this resident was subsequently reported to have died from natural causes. The group general manager is able to detail the other events that require reporting.</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>PA Low</p>	<p>Recruitment processes includes completing an application form, conducting interviews and reference checks. An employment contract and a confidentiality declaration are in staff members' files. One staff member out of 11 staff files sampled did not have a job description, or reference check records or interview records on file. The staff member was employed in February 2018. Staff were unsure where these records were. There are a large number of HR related documents that had yet to be filed.</p> <p>New employees are required to complete a health and safety induction and an orientation programme relevant to their role. A workbook / checklist is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own.</p> <p>Annual performance appraisals have been undertaken with staff who have been employed for 12 months or longer. An assessment using the Nursing Council of New Zealand domains of competency is also completed. Mentoring / coaching meetings also occur in-between times. Records of these are maintained electronically.</p> <p>While records are available that detail some registered health professionals (both employed and contracted) have a current annual practising certificate, these records are not up to date.</p> <p>A staff education programme is in place with in-service education provided monthly. The topics are scheduled to align with Kamo Home and Villages contract with NDHB, residents care needs, and in response to quality and risk data. Education is planned on a month by month basis and is approved by the management team the month prior. The same in-services are scheduled to occur at each of the three KHVCT facilities and staff can attend training at any site. The education programme is overseen / facilitated by the KHVCT educator.</p> <p>Caregiving staff are encouraged to complete an industry approved qualification. There are currently 11 staff working to complete an industry approved qualification in dementia care. Nine staff are completing the third or fourth paper, and two staff are working on the first or second paper. One staff member is doing a level two qualification and one staff member is completing a level three qualification according</p>

		<p>to the education provider's list of staff in training that was sighted at audit.</p> <p>Education topics provided since August 2017 included (but is not limited to); fire safety, Alzheimer's awareness, skin tear prevention, documentation, pressure injury prevention (multiple sessions including by a wound care product supplier, and pressure relieving / preventing equipment supplier and internal sessions), falls prevention, concerns / compliments, new policies, manual handling, incontinence, privacy / confidentiality, restraint minimisation, food safety, performance excellence, managing challenging behaviours, and the Code of Rights.</p> <p>Some staff have completed education related to the provision of palliative care, and management on Nicki T syringe drivers. Education is provided by the educator, group care manager, clinical charge nurse, or other internal or external speakers. Staff can also attend relevant external education. Records of education are maintained, and copies of some education certificates are present in the staff files reviewed. There are processes in place to assess applicable staff for medicine competency. This has not been completed for all applicable staff (refer to 1.3.12.3)</p> <p>Annual competencies for caregivers are in place and linked to the performance appraisal process. There are three rating options (requires assistance, independent and can provide support / guide others in the performance).</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>A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider's contract with Northland District Health Board (NDHB) and safe staffing indicators. The registered nurses have current first aid certificates or advanced cardiac life support certificates as do the three maintenance staff who drive the facility vehicle and two of the activities staff.</p> <p>The rosters for the period 23 April 2018 to 13 May 2018 was reviewed. Any changes in hours worked or the personnel working that is different to that noted on the roster, is recorded. The rosters sighted demonstrated:</p> <p>The clinical charge nurse (CCN), normally on duty Monday to Friday during the day (40 hours a week), is on leave. The CCN hours are additional to the RN's hours rostered providing day to day care. Another RN is rostered non-clinical time between one and three shifts a week. The caregiver hours and RN hours are actively monitored, with the actual and required hours recorded. This data is reported to the board. In the board documents sighted the RN and caregiver hours exceed the required hours to meet safe staffing indicators.</p> <p>The group care manager, group business support manager, group support services</p>

	<p>manager, HR administrator, educator, and the group general manager work week days. These roles provide services for all three facilities and are detailed on the Kamo Home and Village roster. In addition, a receptionist / administrator works 8 am to 3 pm Monday to Friday at Kamo Home and Village.</p> <p>In the rest home and hospital wings:</p> <p>There are two RNs on duty in the morning (AM) and afternoon (PM) shifts, as well as a senior caregiver on each shift.</p> <p>In addition, there are four caregivers rostered to work a full AM shift and another caregiver working until 1.30 pm. There are three caregivers working the PM shift with another caregiver working from 4 pm to 10.45 pm.</p> <p>Overnight there is a RN and two caregivers on duty in the hospital and rest home wing.</p> <p>In the dementia care unit:</p> <p>A RN is rostered on duty each morning seven days a week.</p> <p>There are two caregivers rostered on duty the full morning shift with a third caregiver finishing at 1.30 pm</p> <p>There are two caregivers rostered on duty the full afternoon shift with a third caregiver finishing between 7 pm and 8.15 pm.</p> <p>There is one caregiver on duty overnight in this unit.</p> <p>There are currently staff working towards completing an industry approved qualification (refer to 1.2.7). In addition, 14 caregivers at Kamo Home and Village have completed an industry approved qualification in dementia care, and at least four staff working in the other two facilities (if required). The provider is aware of the DHB contract requirements and staff the secure dementia unit accordingly.</p> <p>A cook is rostered on duty from 7 am to 3.30 pm, seven days a week. Two staff share this responsibility. The main meal is provided at lunchtime. A kitchen assistant works 7 am to 2 pm seven days a week. In addition, a tea supervisor works 3 pm to 6.30 pm seven days a week as well as a tea assistant 4 pm to 6.30 pm every day.</p> <p>Four staff have responsibilities for facility management, maintenance, gardening and repairs across all three facilities owned. All work weekdays.</p> <p>The lifestyle coordinator oversees the activities programme and works Monday to Thursday 8 am to 3.30 pm and Friday 8 am to 12 pm and oversees the activities</p>
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		<p>programme across all three facilities. Activities are provided weekdays by four activities staff. Staff are allocated an area they are responsible to facilitate for the daily programme. In the hospital / rest home wings at Kamo Home and Village a staff member works 9.30 till 3.30 pm weekdays. Another activities staff member works three days a week in rest home / hospital area from 9am or 9.30 am to 3pm or 3.00 pm (weekdays). A diversional therapist works in the dementia care unit providing activities from 9.30 am to 3.30 pm weekdays.</p> <p>Staff responsible for laundry services are rostered on duty, seven days a week. In addition, several staff responsible for housekeeping are rostered on duty every day with staggered start and finish times. There are five staff rostered on housekeeping duties (cleaning and laundry) each weekday, and three staff on the weekend.</p> <p>Kamo Home and Village has introduced a monitoring programme in response to staff unplanned absences when working weekend shifts. All staff away are followed up by the HR administrator as a courtesy check. Monitoring is occurring and the group general manager advises staff who do not complete rostered shifts on the weekend are not offered the opportunity working additional shifts during the weekdays.</p> <p>Residents and the family members interviewed confirmed their personal and other care needs are generally met. In the event of concerns these have been raised directly with applicable staff. Some residents reported having to wait for staff to answer the call bell, but they were overall satisfied with their care and with staff.</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>PA Low</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 staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Not all staff who administer and/or check 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 weekly.</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 was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were two residents who self-administer medications at the time of audit. Not all 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 Moderate</p>	<p>The food service is provided on site by a qualified chef, two other cooks and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines; however, not all food sighted in fridges throughout the facility were stored or had been disposed of appropriately. The service operates with an approved food safety plan and registration issued by Whangarei District Council which expires 31 July 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Both cooks, along with kitchen assistants, have completed relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment to meet resident's nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and residents' meetings minutes. 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 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</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; however, this was not always evident with challenging behaviours over a 24-hour timeframe for residents assessed as requiring dementia level care. The attention to meeting a diverse range of resident's individualised needs was evident. The facility is supported by one house doctor, two supporting clinical and community pharmacists who visit twice weekly. Two residents have chosen to continue to be supported by their own GPs. The 'house doctor' interviewed along with two supporting clinical and community pharmacists verified that with the new support of the clinical charge nurse and group care manager medical input is now sought in a more timely manner, that medical orders are followed, and care is improving. The house doctor interviewed reported that she is available after hours for medication changes (via the medication electronic device), however for all other after hour situations, the staff are encouraged to seek advice from the local accident and emergency centre or hospital emergency department.</p> <p>Registered and care staff confirmed that care was provided as outlined in the documentation and that they have after hours support from the clinical charge nurse on call. 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, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is overseen by the resident lifestyle co-ordinator (who oversees the three facilities). There are four activities staff rostered to support the residents Monday to Friday from 9.30 am – 3.30 pm. The staff member who supports the resident in the dementia unit is a trained diversional therapist. A chaplain is also available when required.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents individually and as a group. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review. Part of the role of the resident lifestyle co-ordinator is to be the contact person for families of residents entering the facility and will support the family with orientation of the facility, key personnel roles and be the primary contact for families with questions. This support occurs over the first three weeks of admission and is acknowledged by the resident lifestyle co-ordinator as complete at the development and signing of the resident's initial long-term care plans.</p>

		<p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered between 9.30 am and 3.30 pm weekdays. Registered staff can refer residents to the activities staff for extra support if the resident is exhibiting behaviours that the staff are finding difficult to manage. Evidence of positive outcomes were provided; however, these interventions are only provided between 9.30 am and 3.30 pm weekdays by the activities staff. All three services have a specific activities calendar related to that area. It was observed during the late afternoon, an escalation of challenging behaviours exhibited by residents in the dementia unit. While care staff were observed to be actively trying to address these behaviours at the time, a review of challenging behaviour events and strategies for the management of challenging behaviours has not occurred. Residents in the dementia unit do not have an individualised plan of care that details how staff are to manage challenging behaviour over a 24 hour period (refer to 1.2.4.3 and 1.3.6.1). Residents in the rest home and hospital and families/whanau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find their programme interactive.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes and updates to the care plans. This was observed at the time of audit for the 15 residents' files reviewed; however, evaluations did not always include evaluation of restraint and / or enablers (see criterion 2.1.1.4). Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, challenging behaviours and wound management. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>There is a current building warrant of fitness (BWOFF) with an expiry 1 June 2018. Ongoing checks to maintain the BWOFF are occurring. Another company undertakes performance monitoring of clinical equipment. Clinical equipment checked at random have a current performance validation. Electrical equipment sighted at random had evidence of current electrical testing and tag checks.</p> <p>The new resident's bedroom for the provision of end of life care services is fit for</p>

		<p>purpose and appropriately furnished.</p> <p>The ten studio apartments were all reviewed and verified as appropriate for the provision of both rest home and hospital level care. The units have a bed and lounge area, kitchenette and accessible ensuite with toilet, hand basin and shower. Call bells are present in both the bedroom area and bathroom. Grab rails are present in the bathrooms. The call bells have long cords so can be accessible to residents. There is an external door to either a courtyard or deck area from each unit. The units have underfloor heating. One studio apartment is currently occupied by a husband and wife. The unit is suitable for the care of two residents as observed and verified by both residents interviewed. A call bell is present at each bed space. There is a staff office, dirty utility room, and a common lounge area in this wing. The studio apartments are located within the main Kamo Home and Village building and all easily accessible from the other resident care areas.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There have been no changes to the facility that have required a change in the approved fire evacuation plan. Fire evacuation drills are undertaken.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, respiratory tract infections, skin, wound, eye, gastro enteritis and others. The GCM/IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</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. Trends are identified from the past year and this is reported by the Manager Business Support (MBS) to the Group Care Manager (GCM), Group General Manager (GGM), Clinical Charge Nurse (CCN) and staff.</p> <p>The facility has had a total of 56 infections since October 2017 with results including the residents affected in the gastrointestinal outbreak in October of 2017. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required and this was also evidenced in resident's care plans reviewed. Data is benchmarked externally within the group and 'QPS'</p>

		<p>three monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent gastrointestinal infection outbreak that occurred in October of 2017 was reviewed where 16 residents were affected. No staff were affected. The summary demonstrated a process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	PA Moderate	<p>Policies and procedures are available on restraint minimisation and safe use and the use of enablers. These documents are under further review. Areas for improvement have been identified in relation to policy, process and staff training.</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>	PA Moderate	<p>An assessment prior to the use of restraint has not been completed for all applicable residents.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Moderate	<p>This register includes information from all three facilities owned by KHVCT. There is no clear link with restraint usage and the quality and risk programme (refer to 1.2.3.5). The restraint register does not include all applicable residents. Evidence related to the observation / monitoring of residents when restraints are in use is not consistently present in applicable residents' files.</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 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>Quality and risk activities and outcomes are discussed at the monthly management meeting that is attended by the group general manager, the group care manager, the group business services manager and the group support services manager, and the meetings held by the group care manager with the clinical charge nurses of all three KHVCT facilities. Topics discussed include events / incidents, complaints management, infection prevention and control and health and safety. Restraint minimisation and the use of restraints is currently not included or discussed. This was verified by the group care manager interviewed. The organisation's</p>	<p>Restraint minimisation is not explicitly linked to the quality and risk programme.</p>	<p>Ensure the use of restraint is explicitly lined to the quality and risk programme.</p> <p>180 days</p>

		restraint minimisation and safe practice procedure notes all cases of restraint is to be reported to the management team, quality and risk coordinator and trends reported monthly to the health and safety committee and executive committee of the BOT. This is not occurring.		
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA</p> <p>Moderate</p>	<p>Applicable events are being reported in a timely manner and disclosed with the resident and / or designated next of kin. This was verified by residents and all family members interviewed. A review of reported events demonstrated that incident reports are completed in a timely manner. The staff immediately present at the time of the event is required to complete an incident / accident report and this is given to the RN on duty who is responsible for investigating. The reports are then provided to the group business services manager and the human resource / administrator who enter the data onto the incident register. The incident register has multiple search features to enable identification and review of data based on the date, time, resident name, the name of the staff member reporting the event, the type of event as well as other factors.</p> <p>A review of 10 incidents / accident</p>	<p>Actions taken in response to reported events / incidents are not consistently documented in the designated area on the incident forms, or do not include all required components to prevent the event reoccurring. Strategies to reduce and minimise the risk of escalating challenging behaviours for individual residents, and for the residents in general in the dementia unit in the late afternoon are not apparent.</p>	<p>Ensure actions taken in response to accidents and incidents is consistently documented on the incident report or clearly referenced to the resident's care plan, and are monitored for effectiveness.</p> <p>Ensure individualised and unit wide strategies are in place to mitigate the risk of sun downing and other challenging behaviours for residents in the dementia unit.</p> <p>90 days</p>

		<p>reports occurred during audit and included falls, skin tears, missing property, and pressure injuries. In addition, two medicine events were followed up via the complaints process and documents sighted. While immediate actions taken in response to the events are detailed, actions to mitigate ongoing risk are not clearly detailed / evident, with the exception of wound care, pressure injury and medicine events. For these events, information was documented in the residents' files sampled or other associated documentation. For the other events, evidence of monitoring that the identified actions had been implemented and monitored for effectiveness were not sighted.</p> <p>Examples sighted included two residents who had been pushed by another resident resulting in a fall or other injury. The actions documented were focused on the fall / injuries rather than actions that caused this. Another resident has a fall prior to an outing. While a plan was noted to address this, there is no evidence of monitoring to verify the identified actions from a systems perspective have been taken and were effective. Another resident had a fall and was transferred to hospital for review / assessment. There is no information readily available to</p>		
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		<p>detail what actions were taken to mitigate ongoing falls risk on the resident's return.</p> <p>It was observed during the late afternoon, an escalation of challenging behaviours exhibited by residents in the dementia unit. While staff were observed to be actively trying to address these behaviours at the time, a review of challenging behaviour events and strategies for the management of challenging behaviours has not occurred, Residents in the dementia unit do not have an individualised plan of care that details how staff are to manage challenging behaviour over a 24-hour period (refer to 1.3.6.1).</p> <p>Staff communicated incidents and events to oncoming staff via the shift handover. Incident and accident data has been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted.</p> <p>The service is benchmarking falls and pressure injury rates per 1000 occupied bed days with other aged residential care facilities in NDHB region as well as nationally with other providers and with Australian facilities. The DHB has undertaken a review of pressure area prevention and management processes in September 2017. Residents with a pressure injury</p>		
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		have had these events reported via the incident management system. Relevant care plans are in place, wound monitoring and care is occurring and additional prevention strategies put in place to minimise ongoing risk.		
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	PA Low	<p>Copies of the current annual practising certificates (APCs) were sighted for two pharmacists, the dietitian, the physiotherapists, the group general manager, the group care manager, the clinical charge nurse, some of the RNs, and the podiatrist. The APC records on file for the general practitioner (GP), four locum GPs, and for five of the registered nurses was not current. Current APC data was sighted for the RNs prior to the audit being completed and had been requested from the GPs.</p>	<p>The annual practising certificates and associated records for registered health professionals (employed and contracted) are not current.</p>	<p>Ensure processes are in place to monitor and ensure records are available to demonstrate that all registered health professionals providing services / care have current annual practising certificates.</p> <p>180 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>The staff knew the residents well and when interviewed could recall the proper procedures required when administering and supporting residents with medication. Safe medication administration to residents was also observed at the time of audit. On review of staff files, three registered nurses, and three out of four caregivers whose competencies were reviewed did not have a current medicine competency (completed in the last 12 months).</p>	<p>Not all registered staff and caregivers who support residents with medication have a current medicine competency.</p>	<p>Ensure all staff responsible for administering or checking medicines have a current medicine competency.</p> <p>180 days</p>

<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>At the time of audit, one of two residents self-administering medications, did not have an assessment to demonstrate competence. Medications for both residents were not stored securely. In discussions with the registered nurse, it was reported that both residents were competent in the self-administering of their medication. The GP had completed three monthly reviews, the medication was prescribed, and it was acknowledged on the electronic device that the residents were self-administering the medication.</p>	<p>A resident self-administering medicines does not have an assessment on file verifying the resident has been assessed as safe to self-administer medicines. Medicines self-administered by residents are not stored appropriately/securely.</p>	<p>Ensure a process is implemented to assess and monitor resident's safety to self-administer medicines. Ensure medicines self-administered by residents are stored securely.</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>	<p>PA Moderate</p>	<p>Food procurement, production and preparation comply with current legislation and guidelines. The cook interviewed was aware of the guidelines. Not all food in the fridges of the four kitchenettes had food covered or dated. The fridge in the dementia unit had food in two plastic bags that was unrecognisable. Food was sighted as covered but not dated in one of the fridges in the main kitchen.</p>	<p>Not all food in the fridges are covered and have expiry dates documented. Expired food was found in the fridge in the kitchenette.</p>	<p>Provide evidence that that storage of food complies with current legislation and guidelines.</p> <p>90 days</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</p>	<p>PA Moderate</p>	<p>Evidence was not documented in care plans to identify challenging behaviours and activities over a 24-hour period or strategies for minimising challenging behaviours. Family/whanau of residents living in the dementia unit reported that</p>	<p>Five out of five residents' files reviewed in the dementia unit did not have care plans that document a description of how the resident's behaviour is managed over a 24 hour period.</p>	<p>Develop individualised care plans for residents in the dementia unit that detail how to manage challenging behaviours over a 24 hour period.</p>

<p>outcomes.</p>		<p>staff are aware of resident's individual needs and challenging behaviours are managed appropriately. Challenging behaviours were recorded and documented in resident's individual progress notes reporting the time, date, behaviour and outcome of any event. Staff interviewed were able to report interventions for individual residents to reduce and minimise risk. Observing at time of audit it was obvious that the staff knew the residents well and their behaviours though unpredictable were managed with the resources that the staff had at the time.</p>		<p>90 days</p>
<p>Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>PA Moderate</p>	<p>A policies and associated procedure is available on restraint minimisation and safe use, and the use of enablers. The restraint minimisation policy and associated procedure has been recently updated. The organisation's policy has historically allowed an EPOA to consent for the use of enablers. This has changed (April 2018) and is now categorised as a restraint. However, the changes in policy have yet to be fully implemented in practice. The policy and associated procedure is under further review to provide more clarity around requirements, including service delivery requirements for staff. There are components where restraint and enabler terminology are used interchangeably in some</p>	<p>The organisation policy and procedure documents on restraint minimisation and safe use and enablers is not sufficiently detailed to provide clear guidance for staff on the use of enablers and restraints. Some of the caregivers interviewed were unaware of recent changes in the organisation's policy.</p>	<p>Ensure the organisation's policy and procedure related to restraint minimisation and enabler use provides clear guidance for staff on expected practice, that the policy is consistently implemented, and that staff are provided with updated education on the requirements.</p> <p>90 days</p>

		<p>of the documents sighted. For example, 'KHVCT recognises that in certain situations, to promote independence, safety and comfort, enablers may be required that constitute restraint'. The restraint authorisation form includes 'I (named person and relationship to the resident) authorise the physical restraint of the named resident. I acknowledge that an adequate explanation of the need for an enabler has been given to me'.</p> <p>Policy notes enablers promote independence, safety and comfort of residents and is voluntary. The service identifies the use of enablers should be detailed in the resident's care plan. Staff interviewed were aware the use of enablers must be voluntary.</p> <p>The restraint coordinator for KHVCT is the group care manager. The position role and responsibilities are detailed.</p> <p>One resident is noted on the register to have enablers (a lap belt and bed rail) in use, although it was noted to be discontinued in February 2018. This resident was sighted with a bedrail up during audit. The resident's spouse advised the bedrail is being used consistently by staff when the resident is in bed and is unconcerned about this. The resident's current care plan does</p>		
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		<p>not refer to the use of enablers.</p> <p>A resident in the dementia unit has restraints in use. These are being managed as an enabler (refer to 2.2.2.1, 2.2.3.4 and 2.2.3.5).</p> <p>Another resident has the use of bedrails documented as an enabler in the resident's care plans with the consent for use signed by the resident's spouse. It was unclear if this was being used as an enabler or a restraint. The resident is currently recorded on the enabler register.</p> <p>Another resident was observed in a lazy boy chair in their bedroom and was positioned in a way that the resident could not get out of independently nor call for help. This was being considered by staff as an enabler.</p> <p>Another resident has a bedrail in use as an enabler. The care plan references the need for and use of an enabler. The resident interviewed verified the use of the bedrails when in bed was at the resident's choice. Another resident who has an enabler documented to be used in the care plan.</p> <p>Some of the caregivers interviewed were not aware of the monitoring process for residents when restraints are in use and were unaware of the recent changes to policy / practice. The two RNs</p>		
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		interviewed were aware of the recent changes to the restraint policy. Training on restraint and enablers is included in the orientation programme for new staff. Twelve staff attended education on managing challenging behaviours in November 2017, and five staff attended training on restraint minimisation.		
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint</p>	<p>PA Moderate</p>	<p>A resident in the dementia unit is noted in their care plan to have a lap belt, lazy boy chair and bedrail in use as an enabler, and this is noted on the enabler register. The most recent interRAI assessment notes an enabler is used when in the chair. However, this is a restraint, and the resident's details are not included on the restraint register. A completed restraint consent form was not present on the resident's file when reviewed with the group care manager and the RN on duty. The specific assessments required prior to the use of restraint have not been completed as staff are still managing these as an enabler (refer to 2.2.3.4 and 2.2.3.5). Caregivers working in the unit verified this. The group care manager advised this resident's records had not yet been updated to reflect the recent changes in the organisation's policy. This resident has previously had a number of</p>	<p>A resident with restraint in use did not have the restraint use assessment undertaken prior to the use of restraints.</p>	<p>Ensure appropriate assessments (that includes all components to meet these standards) are consistently undertaken prior to the use of restraint.</p> <p>90 days</p>

<p>(which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.</p>		<p>falls. None have been reported in recent months.</p> <p>A completed assessment related to the use of restraint was completed in the three other residents' clinical records.</p>		
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	<p>PA Moderate</p>	<p>The restraint register notes there are three residents with restraint in use. For one resident the pre-restraint assessment has been completed, the restraint authorisation form (consent form) is signed by the EPOA and restraint alternatives that were attempted are detailed. The use of bedrails is noted in the care plan as an enabler (although this is being managed as a restraint). The ongoing use of restraints has been reviewed for this resident and is noted to still be required. Restraint monitoring forms are in place although are not consistently completed each shift by caregiving staff in the five days sampled (2-5 May 2018 inclusive).</p> <p>Two other residents have restraints documented in use. They are noted on the restraint register. The required pre-restraint assessment form has been completed, and written consents obtained. The use of restraint is included in the resident's care plan. Monitoring forms are not in use for either of these residents, although a turning chart is being used to record</p>	<p>Evidence of observation / monitoring is not consistently present in the resident's clinical record for when restraints are being used.</p>	<p>Ensure records are available to demonstrate that observation / monitoring consistently occurs for all residents with restraints in use, as detailed on organisation policy and / or in the resident's care plan.</p> <p>90 days</p>

		<p>pressure injury prevention activities for one of the residents. A review of incident data identified there have been no restraint related incidents reported for these residents since the use of restraint was commenced.</p> <p>Restraint monitoring forms are not being used in the dementia unit for a resident with restraints in use (refer to 2.1.1.1 and 2.2.2.1) as staff are managing this as an enabler.</p>		
<p>Criterion 2.2.3.5</p> <p>A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.</p>	PA Low	<p>The restraint register notes there are three residents with restraint in use. The register does not include details of one resident in the dementia unit with restraint in use as this is currently being managed by staff as an enabler. Another resident with bedrails in use has consent for use signed by the EPOA. Staff are managing this as an enabler (refer to 2.1.1.4).</p>	<p>The restraint register does not included details of all residents with a restraint in use.</p>	<p>Ensure the restraint register is current and includes all restraints in use.</p> <p>180 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.