

Kingswood Healthcare Morrinsville Limited - Kingswood Rest Home

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:

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| Legal entity: | Kingswood Healthcare Morrinsville Limited |
| Premises audited: | Kingswood Rest Home |
| Services audited: | Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 2 July 2019 End date: 2 July 2019 |
| 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: | 39 |



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 |
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|  | 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 |
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| 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

Kingswood Rest Home, Morrinsville, is owned and operated by Kingswood Healthcare Limited a private company, who have been providing rest home and dementia level care in the Waikato region since 2012. The Morrinsville facility comprises two secure dementia units and a rest home situated in three separate buildings on the same site. The maximum number of residents who can be cared for is 44.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider's contract with the Waikato District Health Board (Waikato DHB).

Changes within the services being provided have been turning the larger secure unit into a male only environment. The long serving RN clinical manager left on 1 June 2019.

The service provider had requested approval from the Ministry of Health to increase the number of dementia beds on site. The auditors could not endorse increasing the number of beds on the day of audit, due to the unsuitability of the proposed space, current under staffing, and issues with some aspects of service delivery.

Residents, relatives and a general practitioner interviewed expressed overall satisfaction with the care and quality of services provided.

Seven improvements are required as a result of this audit. These relate to complaints management, staffing, the quality system, activities, care planning, and the documentation of controlled medicines and surveillance of infections.

Consumer rights

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The complaints management policy meets the requirements as outlined in right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The General Manager (GM) explained how the complaints received since the previous audit have been resolved.

Organisational management

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| 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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. The GM is suitably experienced and responsible for monitoring of the services provided in both facilities owned by the company. Quality and risk management systems include collection and analysis of quality improvement data to identify trends and improvements required. Feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures were current and were shown to be reviewed regularly.

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

Except for one dementia unit, the staffing levels on the day of audit were satisfactory.

Continuum of service delivery

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| <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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Residents' of Kingswood Rest Home Morrinsville have their needs assessed on admission. Shift handovers and handover sheets guide continuity of care.

Care plans are individualised, based on a range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is good.

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

Medicines are managed according to policies and procedures and implemented using a manual system. Medications are administered by either a registered nurse or care staff, all of whom have been assessed as competent to do so.

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

Safe and appropriate environment

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| 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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There is a current building warrant of fitness.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The service provider has a philosophy of no restraint. There were no restraints or enablers in use on the day of audit. Policies and procedures meet the requirements when a restraint is required and staff education is ongoing

Infection prevention and control

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| 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. | | Some standards applicable to this service partially attained and of low risk. |
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Aged care specific infection surveillance has been undertaken. Follow-up action was taken as and when required.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 0 | 9 | 0 | 2 | 5 | 0 | 0 |
| Criteria | 0 | 32 | 0 | 2 | 5 | 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | PA Low | <p>Policy meets the requirements as outlined in right 10 of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>The complaints register contained four complaints received in 2018. There was insufficient evidence that these had been formally acknowledged and there was scant information about investigation and resolution of each matter. Residents and the family members interviewed confirmed knowledge of the ways to lodge a complaint. The GM stated there had been no complaints about the service to the Office of the Health and Disability Commission or the DHB.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Policies and procedures are in place if interpreter services are required. There were no non-English speaking residents on the day of audit.</p> <p>The GP and family members interviewed said they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented on the accident/incident forms and in the residents' progress notes sighted.</p> |

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| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The company Kingswood Health Care Limited, keeps current an overarching strategic/business and risk plan for the two facilities it operates. There are separate goals for each facility. The documents reviewed and interviews with the GM confirmed that progress against goals and other operational matters are addressed at monthly shareholders meetings.</p> <p>On the day of audit there were 39 residents on site. The service can accommodate a maximum of 44 residents. Thirteen of the 16 available rest home beds were occupied and 24 of the 28 dementia beds were occupied. Ten residents were in one unit and fourteen male residents in the other. Three people were under the age of 65 years but all were funded under the Age Residential Care contract.</p> <p>The GM is responsible for day to day operations and oversight of care provided at each facility. They stated they aim to spend 50% of their time at each site during the week. This person confirmed they attend ongoing performance development in subject areas related to management. They have ongoing liaison with other age care providers in the area and regular contact with relevant DHB staff.</p> <p>Interviews, observations and records sighted reveal a number of changes since the certification audit in December 2016. Following the admission of high-risk male residents, the two dementia units have been re-designated. One is for male only occupants and the other is for female residents and males who present no risks. The long serving clinical manager left the service on 01 June 2019. A temporary RN has been filling the vacancy and recruitment is underway for a replacement.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>PA Moderate</p> | <p>The organisation's annual quality plan, business plan and associated emergency plans, document actual and potential risk to the business, service delivery, staff and/or visitors' health and safety.</p> <p>The quality and risk management system includes conducting internal audits and the collection and monthly analysis of quality data. Graphs with month by month statistics recording the number of falls, skin tears, bruises, behavioural challenges, property incidents, staff injury and medicine errors along with a narrative summary are printed and displayed in staff areas; however, this has not occurred since May 2019. Staff confirmed that adverse events are communicated at handover. There was documented evidence of corrective actions on incident/accident reports up until May 2019 and staff were informed about actions required to prevent incidents by written memos. Where internal audits reveal a deficit or gap, remedial actions are documented by the GM. The hazards register was current and showed evidence of being updated.</p> <p>Policies and procedures are updated as required to meet current best practice and were current.</p> <p>Residents and their family members confirmed they are consulted about any proposed changes in service and are being kept informed at regular residents' meetings and via newsletters.</p> <p>Health and safety policies are compliant with the current legislation and interviews confirmed that the owners understood their obligations. Environmental risks are communicated to visitors, staff and residents as required</p> |

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| | | through notices, or verbally, depending on the nature of the risk. Review of staff records showed that health and safety education is provided at orientation. Fire drills are occurring every three months. |
| <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 were reliably documenting all adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, and that up until May were investigated by the clinical manager, action plans developed and implemented in a timely manner. Adverse event data was being collated, analysed and reported to staff and the GM each month but this ceased after May 2019. (Refer corrective action in 1.2.3.6) The collated results and a narrative summary used to be displayed in the staff room. Staff however confirmed that they are advised about incidents and accidents at handover, and incident reports were available in each unit.</p> <p>The GM understands the essential notification reporting requirements. There have been three notifications made to the Ministry of Health and DHB since the previous audit. These included the death of a resident and coroner's inquest in January 2017, a resident who went missing from the secure unit in January 2019 and assault to a resident by another resident in January 2019.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>All staff and contractors who require an annual practising certificate (APC) have these validated at employment and annually. A register is maintained of when APCs and competency assessments are due. Copies of APCs were sighted for the staff who require them. Staff files evidenced appropriate processes are implemented for the recruitment, employment and orientation of new staff.</p> <p>All new staff undertake an orientation that includes the essential components of service delivery and health and safety. All staff are required to complete a Spark of Life course and are required to demonstrate the philosophies of the resident centred care, as well as the Kingswood Healthcare's philosophy All staff who have worked at the service for longer than six months have completed the dementia unit standards, with newer staff now enrolled in the Careerforce and on target to complete these within the 18 month timeframe stipulated in the ARCC.</p> <p>The temporary RN on site was an interRAI trainer and demonstrated knowledge on the use of this tool to assess resident's needs to inform the care planning process.</p> <p>The sample of staff records reviewed and interviews with all staff confirmed that each person engages in an annual performance appraisal.</p> <p>The ongoing education programme meets contractual requirements for the delivery of care to residents living with a cognitive impairment. Attendance records are maintained to evidence the implementation of the ongoing education programme. Staff reported they have access to both external and in-service education. The in-service education includes training specific to dementia care.</p> |

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| <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>PA Moderate</p> | <p>There is clearly documented policy on staffing levels and skill mix, but on the day of audit, staff sickness resulted in there not being enough staff in the male secure dementia unit. Two caregivers are rostered on in each of the three units for morning shift, one in the afternoon and one at night, plus an additional short shift person from 3pm to 8pm. On the day of this unannounced audit, five staff were absent because of illness which potentially compromised safe service delivery. Improvement is required. An RN is on duty for eight hours, four days a week, and on call 24/7. Staff records reviewed and interviews confirmed that there is at least one staff member on duty each shift who has current first aid qualifications.</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 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 a manual 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. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by two caregivers against the prescription, in two of the three units only. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are identified as being checked by two staff for accuracy in administration, however this was observed to not have occurred on two recent occasions and this requires attention. 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 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.</p> <p>There were no residents who were self-administering medications at the time of audit; however, appropriate processes are in place to ensure this can be managed in a safe manner in the rest home, if required.</p> <p>Medication errors are reported to the senior caregiver and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> |

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| | | Standing orders are not used. |
| <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> | FA | <p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian on the 21 September 2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Matamata District Council. A verification audit has been undertaken on the 14 March 2019, and a new registration provided that expires 2 May 2020.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and residents' family members interviewed, satisfaction surveys and residents' meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal-times to ensure appropriate assistance is available to residents as needed.</p> <p>Food is accessible at any time for residents in each of the secure units.</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> | FA | <p>Except for those files referred to in criterion 1.3.3.4, documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. Several residents in each of the two secure units with complex behaviours that challenge have behaviour management plans in place, with ongoing monitoring of the effectiveness of interventions. The attention to meeting a diverse range of resident's individualised needs was evident in service provision. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. 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> |
| Standard 1.3.7: Planned | PA | The activities programme at Kingswood is provided by one of the two care staff in each of the three units and |

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| <p>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>Moderate</p> | <p>overseen by an activities co-ordinator. The activities co-ordinator is undertaking training in maintaining an activities programme that is based on the philosophy of fostering an attitude of unconditional love. The activities co-ordinator is being supported in the role by a practitioner qualified in implementing this philosophy in caring for residents with dementia.</p> <p>A social assessment and history are undertaken on admission to the two secure units to ascertain residents' needs, interests, abilities and social requirements. There are however no formal individualised activities plans that address each resident's activity needs or desired goals. There was no social assessment sighted in the two files reviewed of residents in the rest home. An interview with the activities co-ordinator, identified that this has not been addressed at this time due to changes in staffing.</p> <p>Activities provided are regularly reviewed to help formulate an activities programme for the residents. The resident's activity needs are evaluated regularly based on resident participation.</p> <p>Individual, group activities and regular events are offered. Examples included bowls, housie, the newspaper reading, cooking, meal preparation, and assisting with chores around the unit. Programmes in the secure units are flexible based on resident status each day. A 'men's shed' operates on a Friday, with the men in the unit working on making wooden items with the oversight of a caregiver who is a qualified carpenter. The male unit has movie nights that includes making popcorn. The programme in the other secure unit is lower key, as is the programme in the rest home. The programme in one of the secure units was observed to be ongoing all day, with the residents participating in several household chores. On the day of audit, there was minimal activities taking place in the male unit and the rest home. An interview with a caregiver in the rest home said the residents had requested to watch the tennis on the day of audit.</p> <p>The activities programme is discussed at the minuted rest home residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction, however three complaints received within the last six months referred to a lack of activities being provided (refer criterion 1.1.13). Residents interviewed in the rest home confirmed there is very little going on.</p> <p>A residents/family newsletter captures activities in the men's shed, an outing to the car museum, a ladies outing to a castle in Tirau and the regular presence of the therapy dog.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p> | <p>FA</p> | <p>Resident care is evaluated on each shift, by care staff and reported in the progress notes. If any change is noted, it is reported to the senior caregiver, who liaises with the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. With the exception of that referred to in 1.3.3.4, evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the care provided, after seeking guidance from the RN. Examples of short-term care plans were consistently reviewed for behaviours that challenge, pain, and weight loss and progress evaluated as clinically indicated and according to</p> |

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| timely manner. | | the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| <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) in each of the three buildings. The rest home building WOF expires on 16 March 2020, the men's secure unit expires on 04 November 2019 and the other secure unit expires on 6 December 2019. There have been no changes to the building structure. Scheduled maintenance and inspections on the buildings and equipment is occurring, as are trial fire evacuations.</p> <p>The service provider had requested approval to increase the number of dementia beds in the male dementia wing. Building alterations had not commenced and the plans were not available to view. The auditors consider the proposed room as unsuitable due to its size, and lack of day light. The room, which is currently used as an office, had one smaller than normal sized window at the end of a narrow space. There is no interior or exterior space for increasing the size of the room and adding windows. The GM stated the request was for an increase of two beds, not three as stated on the reconfiguration letter dated 21 June 2019. There are already five shared bedrooms and six single occupancy rooms in the unit. Progressing the reconfiguration is not approved due to this and the findings on audit day around staff shortages and failure in systems.</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> | PA Low | <p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The RN, when present, reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. However, surveillance data has not been collected at Kingswood rest home since April 2019.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The service provider has a philosophy of no restraint, although staff had been trialling bed rails, upon family request, with one resident in March 2019. Assessment, consent and monitoring had occurred until the bedrails were discontinued a week after commencement. The resident is now sleeping on comfortable mattresses on the floor. There were no restraint or enablers in use on the day of audit. Policies and procedures meet the requirements when a restraint is required, and staff education is ongoing</p> |

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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) |
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| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low | The complaints register contained four complaints received in 2018. There was no documented evidence that these had been formally acknowledged and insufficient information about investigation and resolution of each matter. Where information could be found, this was spread across various emails, or scribbled on loose pieces of paper. The only evidence of resolution about the matters was the testimony of the GM. | The complaints register did not include the information required to provide an auditable record of the complaint management process. | Ensure that all complaints received are acknowledged in writing, that evidence of investigation and actions taken is documented and filed with each complaint along with proof that resolution was reached and that the matter |

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| | | <p>added responsibility for overseeing the site was ill and not due back until the following week. The activities coordinator was nominated 'in charge' that day but was not suitably experienced for the role. The second caregiver in the male dementia unit had called in sick but the absence was not reported by the staff member on duty, who had been working on their own from 6am with 14 male residents some of whom were assessed as high risk. No actions had been taken to cover the second carer's absence until the GM arrived on site. The sole carer stated they were planning to stay on shift until 10pm. Interviews with three residents in the rest home, identified shortages of staff due to sickness is a frequent occurrence, with staff having to work short. Two family members visiting the male dementia unit, commented on the lack of activity.</p> <p>The second caregiver in each unit is expected to carry out daily cleaning and laundry, and these tasks were not happening in the male unit until a housekeeper from the other facility was deployed to Morrinsville to assist. Five care staff from all shifts did however state that cleaning and laundry services were usually easily accommodated within their workloads and that generally there were sufficient staff. They said the lack of staff on the day of audit was unusual.</p> <p>The service provider was active in trying to recruit more staff urgently. An applicant arrived for interview on the day of the audit and more interviews were planned for the following week.</p> | occupants. | of them. 7 days |
| <p>Criterion 1.3.12.1 A medicines management system is implemented to</p> | <p>PA Moderate</p> | <p>A medication round was observed, and fourteen medication charts reviewed. Evidence was sighted of three-monthly medication reviews. Reconciliation of medicines was occurring in two of the three units. The file containing reconciliation records was not able to be found in the rest home. Reconciliation is undertaken by two</p> | <p>The reconciliation of medicines and the safe administration of controlled drugs in the rest home was not occurring as required.</p> | <p>Provide evidence that reconciliation of medication occurs for each unit, with input</p> |

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| manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | | <p>medication competent caregivers, not with the RN.</p> <p>A check of controlled drugs and the register identifies two doses of a controlled drug being signed out by only one person. The administration record for that drug has also been signed by one person only. An interview with a caregiver identified they had forgotten on two consecutive days to co-sign the register. The caregiver however was not medication competent and therefore should not have been the second checker. This was reported to the RN, who verified the inaccuracy in controlled drug management. The RN reported they will commence a corrective action process.</p> | | <p>from the RN. Provide evidence that a safe system operates to manage the administration of controlled drugs.</p> <p>30 days</p> |
| <p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p> | PA Moderate | <p>Systems at Kingswood are in place to promote continuity of care with verbal handovers and handover reports; however, the recent absence of regular RN cover and trained clinical oversight and direction has led to a lack of clinical guidance (refer criterion 1.2.8.1). A review of seven files identified four residents (including a respite resident) with no care plan in place to describe the care required to meet the residents' assessed needs. There was no system in place to verify the RN reviewed the residents' daily progress on a routine basis. Four of seven files reviewed, had no evidence of RN documentation within the last month and one resident had had no review since February 2019.</p> <p>A review of complaints identified a complaint has been received within the last six months regarding a resident not receiving the care the resident requires, or as requested by the family. The resident has since transferred out of Kingswood.</p> | The absence of recent regular RN oversight and clinical guidance has led to, residents not being reviewed by the RN on a regular basis and resident care plans not being in place or updated to reflect the care the resident requires | <p>Provide evidence an RN is available to provide ongoing clinical oversight, guidance, review and direction in the provision of resident care.</p> <p>90 days</p> |
| <p>Criterion 1.3.7.1</p> <p>Activities are</p> | PA Moderate | The caregivers in each unit provide the activities programme for the residents, based on an activities plan | There is no evidence to support the activities provided are developed to | Provide evidence that |

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| <p>planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | | <p>implemented by the activities co-ordinator. A social assessment and history are undertaken for residents in the secure unit, however there is no formal activities plan in place for each resident that correlates to the information documented in the assessment. No social assessment was sighted in the two files reviewed of residents in the rest home. An interview with the activities co-ordinator, identified that this has not been addressed at this time, due to changes in staffing. Activities assessments where present, are not regularly reviewed to help formulate an activities programme that is meaningful to the resident.</p> <p>Three complaints received within the last six months, referred to a lack of activities being provided. The programme in one of the units was observed to be ongoing all day. On the day of audit there was minimal activities taking place in the male unit and the rest home. An interview with a caregiver in the rest home said the residents had requested to watch the tennis.</p> | <p>maintain strengths, skills and interests that are meaningful to the resident.</p> | <p>activities are planned and facilitated to develop residents' skills strengths and interest. Provide evidence of assessment, implementation and evaluation of the activities programme.</p> <p>90 days</p> |
| <p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management</p> | <p>PA Low</p> | <p>Graphs were sighted that present the incidents of infections, analysis of infections and required actions regarding infections at Kingswood. However, surveillance data has not been collected or analysed since April 2019. Results of the surveillance programme are not shared with staff via quality and staff meetings (refer criterion 1.2.3.6). Interviews with staff verified any incidents of infections are reported and discussed at staff handovers. Surveillance data up until April 2019 was entered in the organisation's infection database.</p> | <p>Surveillance and analysis of infections has not occurred at Kingswood since April 2019.</p> | <p>Provide evidence that surveillance and analysis of infections is occurring.</p> <p>30 days</p> |

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| in a timely manner. | | | | |
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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.

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End of the report.