

Kamo Home & Village Charitable Trust - Kamo Home and Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Kamo Home & 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: 23 January 2020 End date: 24 January 2020

Proposed changes to current services (if any): Another one of the ten studio units (unit five) in Tuatara Courts has been assessed during this audit as suitable for providing rest home or hospital level care for two persons. This now makes a total of three studio units (unit four, five and ten) as having been assessed at this or prior audits as suitable for dual occupancy.

Total beds occupied across all premises included in the audit on the first day of the audit: 67



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kamo Home and Village Charitable Trust – Kamo Home and Village – provides rest home, secure dementia, and geriatric hospital care for up to 72 residents. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner. The audit included verification that a studio unit in Tuatara Court (unit five) is suitable for the care of two residents. This has increased the certified bed numbers by one.

The audit has resulted in three continuous improvement ratings in relation to using quality improvement data to improve systems and services, the establishment of a new general practitioner link nurse role and dementia unit support group. No areas requiring improvement were identified.

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.

All standards applicable to this service fully attained with some standards exceeded.

The Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a Maori Health Plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained, and training is provided.

Open communication between staff, residents and families/whanau is promoted and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers which contributes to ensuring the services provided to residents are of an appropriate standard.

Complaints are managed efficiently and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation's philosophy, mission and vision statement are identified in the business (2018-2020) and the strategic (2016-2025) plans. The group general manager, the Kamo Home and Village clinical charge nurse, and the other two members of the management team work together to ensure service planning includes all relevant aspects of service. The services offered meet residents' needs, legislative requirements and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems included an internal quality check (audit) process, incident/accident reporting, hazard/risk management, resident and staff satisfaction surveys, restraint minimisation, monitoring of restraint and enabler use, and infection control data collection. Quality and risk management activities and results are shared amongst the management team, staff, residents and families, as appropriate. Corrective action planning is well documented. A range of quality related data is monitored via an external benchmarking programme. Appropriate policies and procedures are available for staff reference.

New staff have an orientation appropriate for their role. Staff participate in relevant ongoing education, which includes an annual competency assessment programme relevant to each role. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that they were satisfied with the staff and care provided.

Staffing numbers and skill mix aligns with the organisation's policy. There is always a registered nurse on duty, usually more. Staff working in the secure dementia unit for more than 18 months have completed an industry approved qualification in dementia care.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by the group care manager, clinical charge nurse, general practitioner link nurse and allied health staff. There is a designated general practitioner. On call arrangements are in place. Shift handovers and effective communication guides continuity of care.

Care plans are individualised based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All electronic residents' records reviewed demonstrated that needs, goals and outcomes were identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in multidisciplinary team meetings, care planning and evaluation and that care provided was of a high standard. Residents are referred or transferred to other health services as required with appropriate verbal and written handovers.

The planned activities programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains links with the community. One on one activities are also promoted.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff all of whom have been assessed as competent to do so.

The catering service meets the nutritional needs of the residents with special needs being catered for. Policies and procedures guide the chefs supported by staff with food safety qualifications. The kitchen was well organised, clean and meets all food safety

standards. The food control plan was displayed and was current. Residents and family members verified satisfaction with meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Waste and hazardous substances are well managed. Staff have available and use appropriate protective equipment and clothing. The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Clinical equipment has undergone clinical calibration/performance monitoring checks. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Chemicals, hazardous substances and equipment are safely stored. Laundry is undertaken onsite. Cleaning and laundry services are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is appropriately maintained. Security cameras are in use.

Restraint minimisation and safe practice

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

Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no restraints in use at the time of audit. Nine residents were using enablers. Staff are provided with training on restraints and enabler use during orientation and as a component of the ongoing education programme. Staff demonstrated a sound knowledge and understanding of the organisation's policies and could detail the processes required in the event that restraints were required to be used.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control management system is appropriate for the nature of this aged residential care service. The programme is reviewed annually and implemented. Infection prevention and control reduces the risk of infections to residents, staff, families/whanau and visitors. Policies and procedures are available to guide staff. Staff are provided with relevant education, as are residents, when appropriate.

The infection control coordinator collates all monthly surveillance data for the service and another two services across the organisation. Where any trends are identified action is implemented. The infection surveillance results are reported at the staff

quality/staff meetings. Expertise is available and can be sought as required. Benchmarking occurs both nationally and internationally.

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	1	44	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the staff training and online education programmes. Residents' rights are upheld by staff. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they understand their rights. The family/whānau reported that residents are treated with respect and dignity.</p> <p>The Code is available in English and te reo Maori and other languages for residents with English as a second language.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided to those family members/representatives with enduring power of attorney (EPOA) and ensuring where applicable this is activated. The residents' records reviewed in the dementia unit showed that their EPOAs were activated and three family members (EPOAs) interviewed were fully informed of their relatives' condition by staff.</p>

<p>make informed choices and give informed consent.</p>		<p>There is a policy on advance directives and advance care planning which meet legislative requirements. An advance directive and advance care plan are used to enable residents to choose and make decisions related to end of life care. The records reviewed had signed advance directives which were reviewed six monthly along with the care plan reviews.</p> <p>Residents and family/whanau (where appropriate) are included in care decisions.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the staff training schedule – as confirmed in the 2019 - 2020 schedule reviewed. The staff interviewed reported knowledge of residents' rights and advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents reported they are supported to maximise their potential and to maintain links with their family and the community through shopping trips, activities, outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available with a designated driver who plans all outings with the activities coordinator. The service fully supports the activities and outings in the community for dementia care residents. The facility has unrestricted visiting hours and encourages visits from the residents' family/whanau and friends. Family/whanau interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<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 members, the managers and staff reported their understanding of the complaints process and this aligns with the policy. Template forms and a drop box are available near the main entrance of the facility so residents and family members can provide feedback or make a complaint at any time. The Ministry of Health 'top tips for making a complaint' were also readily available.</p> <p>A complaints register is maintained by the Kamo Home and Village group general manager (GGM) who is responsible for the complaint's management processes. There have been 20 complaints or concerns received in 2019. This included two complaints that involved independent advocacy services. The group general manager encouraged one of the complainants to involve the independent advocacy services in the complaint resolution process.</p>

		<p>Kamo Home and Village received a complaint in July 2018 via the Health and Disability Commissioner. This has been closed. A review of this and four other complaints verified the service acknowledges, investigates and respond to complaints in a timely manner. The group general manager is aware of the requirements and timeframes for responding to complaints as required by the Code.</p> <p>There have been no complaints via the Ministry of Health, or District Health Board since the last audit. Staff interviewed confirmed they would bring any resident or family member's concerns to the attention of the clinical charge nurse (CCN), the registered nurse on duty, or another member of the management team. Residents and family members interviewed confirmed they were aware of the complaints process. One resident stated she had made a complaint about an aspect of service in the last 12-18 months. This was promptly and appropriately resolved according to the applicable resident.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>A copy of the Code and other information related to rights are in the residents' rooms and displayed throughout the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families as confirmed by interviews with clinical staff. Discussions related to residents' rights and responsibilities take place formally in staff meetings and training forums and informally (e.g., with the resident in their room). A copy of the Code is available in sign language. Residents and family/whanau reported that the residents are addressed in a respectful manner that upholds their rights.</p> <p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service as part of the admission information provided and discussion with staff.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit. Privacy is considered when attending to personal cares. The staff ensured resident information is held securely and privately and that privacy is observed when having conversations with residents and family members. All residents have their own room and this also ensures privacy is maintained.</p> <p>Residents are encouraged to maintain independence by attending activities in the community or by attending groups, clubs and organisations that they were attending prior to admission. Each plan included documentation related to the individual resident's abilities and strategies to maximise independence.</p> <p>Records confirmed that each resident's individual cultural, social and religious needs, values and beliefs had been identified and documented in their care plan.</p> <p>Staff understood the service's policy on abuse and neglect including what to do should there be any signs. No</p>

		concerns were raised in relation to abuse and neglect from residents, the general practitioner (GP) family/whanau and/or staff interviewed. Education on abuse and neglect is part of the orientation programme for staff and is then provided on an annual basis as confirmed in the staff and training records reviewed.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Te Tiriti O Waitangi policy (Treaty of Waitangi) is available to guide staff. A family/whanau approach to service delivery is encouraged. Whanau input and involvement is sought as required for all cares and decision making. The staff training schedule sighted included cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. The staff and whanau interviewed reported that there were no known barriers to Maori accessing the services. The residents who identify as Maori (five residents) are well supported by Maori staff (10 Maori staff) and whanau. All cultural needs are met and were reflected on the individual care plans.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural and spiritual needs of the residents are provided in consultation with the resident and the family/whanau as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Residents verified that they were consulted on their individual ethnicity, culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whanau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation/induction process for staff included education related to professional boundaries, expected behaviours and code of conduct. Registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service encourages and promotes good practice and support through evidence-based policies and input from external specialist services and allied health professionals. The service has access and support from specialist gerontology nurse specialists, wound care nurses and geriatricians as needed. The general practitioner (GP) visits the service at least weekly. Resident and family satisfaction surveys evidenced overall satisfaction with the quality of care and services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included the content covered in the staff training as per the staff records and the training records reviewed and the allocation of primary caregivers to residents throughout all areas of service delivery, and the dementia service environment plan. Quality projects are underway for incidents/accident management and other quality and care initiatives. There were several quality initiatives which evidenced quality continuous improvements in relation to QPS benchmarking reflected in organisational management, the general practitioner link nurse position and role (refer criterion 1.3.3.1) and the Alice Court Dementia Service Support Group.</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>Residents and family members stated they were kept informed about any changes to their/their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the residents' records reviewed. Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services through the DHB though reported this was rarely required due to most residents being able to communicate effectively in English and/or staff were able to translate as needed. There is an interpreter service available for any deaf residents to access if needed. There are communication strategies in place for residents with any cognitive impairment or those who have non-verbal means of communication.</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>The strategic plan (2016-2025) and the business plan (2018-2020) detail the mission, philosophy, values, scope, and goals of the organisation. A summary version is displayed for staff. The values are included in the staff performance appraisal processes. The service is managed by the group general manager (GGM) who is responsible for services provided in the three aged related residential care facilities (including Kamo Home and Village) that are owned and operated by Kamo Home and Village Charitable Trust (KH&VCT). Kamo Home and Village Charitable Trust comprises seven trustees and meets monthly. The group general manager attends these meetings and provides a written report each month to the board detailing current operational and business issues.</p>

	<p>The KH&VCT group general manager is a registered nurse, who maintains a current annual practicing certificate, and has worked for this organisation in a senior manager role for ten years. The group general manager has oversight of services with the support of the clinical charge nurse at Kamo Home and Village who is the manager responsible for the services provided on site and ensuring the day to day care needs of residents are being met. The clinical charge nurse has been in this role since June 2019 and prior to this worked for another aged related residential care provider in senior registered nurse roles.</p> <p>In addition, the management team includes the group support services manager who is responsible for oversight of the catering, laundry, housekeeping and maintenance services provided across the three facilities, and the group care manager (GCM) who is responsible for oversight of care related systems and processes and supporting the clinical charge nurse managers in the three ARRC facilities. The group general manager is also the restraint coordinator for Kamo Home and Village Charitable Trust.</p> <p>The clinical charge nurse at Kamo Home and Village has exceeded eight hours of education per annum related to managing an aged related residential care facility as required by the providers contract with Northland District Health Board (NDHB) with at least 26 hours of education documented as occurring.</p> <p>The management team monitors process in achieving goals via the quality and risk programme, resident and family feedback and during discussions at management meetings, and an annual formal review of the progress in achieving the business plan.</p> <p>The clinical charge nurse is on call afterhours for one week out of every three weeks. For the other two weeks, the afterhours on-call cover is provided by the other two clinical charge nurses employed by Kamo Home and Village Charitable Trust, thereby sharing the on-call service across all three KH&VCT aged related care facilities between them.</p> <p>The facility has an Aged Related Residential Care Contract (ARRC) with NDHB for the provision of rest home, secure dementia and continuing hospital level care. Another contract is for respite care services for older people in residential aged related residential care services. This includes having a dedicated respite bed in the dementia unit. The local needs assessment coordination service (NASC) manages the utilisation of this bed. There is a long-term support chronic health conditions (LTS-CHC) contract for rest home, hospital and secure dementia level of care. There were 67 residents receiving care at the time of audit. This included six residents at rest home level of care, 36 residents at ARRC continuing (hospital) level of care, 23 residents in the secure dementia unit including one respite resident), and two residents under the LTS-CHC contract both at hospital level of care. One of the LTS-CHC residents was under 65 years of age. Some of the residents are living in the three studio units in Tuatara Court certified as being suitable for the provision of either rest home or hospital level care. The other occupants of the units in Tuatara Court have occupational rights agreements in place and were not included in the scope of this audit. There were no borders.</p>
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<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the group general manager's absence, the group care manager and the group support services manager are responsible for the oversight of care and services provided. The chairperson of the board provides assistance and advice as required. The KH&VCT accountant is responsible for approving expenditure over an agreed value. Staff are advised of the GGM planned leave and arrangements made via group messaging. The group care manager was able to detail the responsibilities in the GGM's absence both planned and unplanned.</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>FA</p>	<p>Kamo Home and Village has a quality and risk management system which is understood and implemented by service providers. This includes monthly quality checks (internal audits/reviews, which are to be completed the first week in the month), satisfaction surveys, incident and accident reporting, health and safety/hazard management, infection control data collection and management, and concerns/complaints management. The results of the monthly quality checks (internal audits) are grouped together with other relevant components as determined in a matrix, and the amalgamated results are reported, as part of the balance score card to the management team, staff and the board of trustees to monitor performance over time. The review analysis and communication of quality and risk data with an improvement focus has significantly reduced the number of resident falls with and without injury, pressure injuries and the use of restraint. This is an area of continuous improvement.</p> <p>Staff are provided with feedback and if a significant issue or deficit was found, or the same issue has been identified in two out of the last three quality, or two consecutive quality reviews a formal corrective action plan has been developed to address the situation. In addition, corrective actions have been developed and implemented in response to sampled accidents/incidents, discussions during meetings, and reported maintenance issues. There is monitoring occurring that the actions taken have been effective. An electronic corrective action register is maintained of events that require monitoring over time.</p> <p>The group care manager has monthly meetings with the three KH&VCT clinical charge nurses and discusses relevant issues including the balance score card results and quality improvement activities, restraint minimisation and infection surveillance data with this team. Quarterly benchmarking of a range of quality related data is occurring.</p> <p>The health and safety committee meets three monthly and is attended by representatives from each of the three KH&VCT ARRC facilities. The human resources coordinator is responsible for health and safety reporting to the GGM.</p> <p>Kamo Home and Village Charitable Trust undertakes an annual resident and family satisfaction survey. The</p>

		<p>feedback from the relative satisfaction survey conducted in March/April 2019 was positive about the services provided. A staff satisfaction survey was also undertaken during the same period. The service has summarised the three aspects that staff rate highly as well as the three aspects where there are opportunities to make changes/improvements.</p> <p>Appropriate quality information is shared with staff via shift handover as well as via the monthly 'get the information out there' and quarterly staff meetings. The minutes of these meetings are detailed and made available to staff. The minutes of three meetings were sampled. Staff interviewed verified they were informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations, policies/procedures, incidents/accidents, restraint minimisation, staff education/training, the results of internal audits/surveys, and facility/general business activities.</p> <p>Regular meetings have been held with residents and family members to obtain resident feedback on food, laundry services, the internal and environment, staff identification, changes in podiatrist and the general practitioner, staffing, and activities. The minutes of the last four meetings were sighted.</p> <p>Policies and procedures are available to guide staff practice. These are now available for staff electronically. The group general manager is responsible for ensuring policies are updated according to a schedule with input from the management team and other applicable staff. The group care manager receives electronic reminders when documents are due for review. Electronic archiving of updated policies is occurring. All policies and procedures were current or in the process of being reviewed. Staff interviewed confirmed they can access required policies easily and were informed when policy documents have been updated. Requested policies and procedures were sighted during audit.</p> <p>Actual and potential hazards / risks are identified in the electronic hazard, risk and hazardous substances register sighted. The group general manager described the organisation's risks and ongoing mitigation strategies. The chairperson of the board was interviewed and confirmed being satisfied that new or changing risks are being communicated in a timely manner and appropriate mitigation strategies are implemented. Resident specific risks are evaluated during interRAI assessment and care plan reviews.</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</p>	<p>FA</p>	<p>Policy and procedure detail 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.</p> <p>Applicable events have been reported in a timely manner and since the 28 November 2019 are being reported electronically. Sampled events have been disclosed with the resident and/or designated next of kin. This was verified by residents and family members interviewed, and records of communications maintained in the sampled residents' files.</p> <p>A review of eight reported events including witnessed and unwitnessed falls with and without injury, a</p>

<p>family/whānau of choice in an open manner.</p>		<p>pressure injury, an episode of challenging behaviour, a medication event, and two non-resident related events demonstrated that incident reports are completed, investigated and responded to in a timely manner.</p> <p>Staff advised they now report all incidents/adverse events electronically. The clinical charge nurse advised being alerted electronically whenever an incident is logged by staff. The group care manager is also alerted, and events are included in the shift handover. The group general manager can also review any event in real time. The group general manager undertakes a monthly audit of the incident management system by using tracer methodology audit process to evaluate how randomly selected reported events have been investigated and responded to, and to identify any opportunities for improvement in the process. Incidents/events have been also discussed with staff at the staff meetings as verified by interview. A range of incidents/adverse event data is also included in the external quarterly benchmarking programme and results are received quarterly. The most recent results were sighted during audit. The evaluation and use of quality and risk data including adverse events/incidents data is included in the continuous improvement rating in criterion 1.2.3.6.</p> <p>The clinical charge nurse and the group general manager advised there have been essential notifications to the Ministry of Health and/or District Health Board since the last audit related to the changes in clinical manager, registered nurse recruitment challenges, one shift with reduced caregivers on duty due to unplanned staff absences, a resident fall resulting in a significant injury and episodes of challenging behaviour. The police (on behalf of the Coroner) visited the service in response to the death of a resident. This was subsequently noted as being due to documentation issue rather than an unexpected or untoward death, so a formal investigation did not progress.</p> <p>The group general manager and the group care manager interviewed detailed the other type of events that also require external reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The human resources co-ordinator assists with facilitating recruitment and human resource processes for all three KH&VCT ARRC facilities.</p> <p>The recruitment process included completing an application form, interview, and referee checks. Police vetting is now occurring as staff are employed and a summary of the interview is also being retained. The service has transitioned from having paper based human resource (HR) records to maintaining electronic records. The paper-based records for employees prior to this change are being retained as some historical information is not being incorporated into the electronic file. The job description/employment contract was present in sampled files along with a privacy/confidentiality agreement. A sample of ten staff records reviewed confirmed that policies are being implemented and records retained.</p> <p>All employed and contracted registered health professionals (RHPs) have a current annual practising certificate (APC). Copies of the APCs are on file.</p>

		<p>Staff induction/orientation includes all necessary components relevant to the role. The educator coordinator provides induction days where key topics are discussed with new employees. New staff are allocated an 'on the job coach' to work with for at least three days. Registered nurses have a longer timeframe. Staff reported that the induction/orientation process suitably prepared new staff for their role and responsibilities. Staff records reviewed showed documentation of completed orientation and the associated competency assessment applicable for the role is completed within three months, and subsequently updated annually thereafter.</p> <p>A comprehensive staff education programme is in place with in-service education identified and several opportunities and topics are provided every month. Staff can attend training at any of the three KH&VCT ARRC facilities. Staff have been provided with training on helping residents maintain their oral health. Records of education attendance are maintained.</p> <p>There are 45 caregivers employed. Care staff are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Fourteen staff have completed a level two industry approved qualification, and two staff are currently in training. Twelve staff have completed a level three industry approved qualification and three staff are in training. Fourteen staff have completed a level four industry approved qualification and one staff member is in training. At least 13 staff have completed an industry approved qualification in dementia care, and seven are currently completing this training. All staff employed more than 18 months and who work in the secure dementia unit have completed an industry approved qualification in dementia care. The KH&VCT clinical educator is an approved assessor.</p> <p>An annual performance appraisal is required for all staff, and these have been completed for applicable staff. The process now includes the staff member completing self-reflection prior to meeting with their line manager and completing the mandatory competencies that are specific/relevant to their role. There are systems in place to identify when these are next due.</p> <p>The registered nurses are required to have a current first aid certificate and medicines competency and records are retained of this. New staff are booked to complete first aid training where applicable soon after employment. There is always at least one staff member on duty with a current first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place (refer to 1.2.1), with staff reporting that good access to advice is available when needed. Care staff reported there were enough staff available to complete the work allocated to them and that the system in place to replace absenteeism works well. Residents and family interviewed supported this. Observations and review of a four-week roster confirmed adequate staff cover has been provided. There is always a minimum of three caregivers and a registered</p>

<p>experienced service providers.</p>		<p>nurse on duty, normally more. In addition to the group general manager, group care manager and clinical charge nurses who work weekdays, there are three registered nurses on duty every morning including the weekends, and up to ten caregivers working either a full or part shift on a morning shift. Staff are rostered to work in a designated area of the facility and allocated to work with designated residents. The required and actual RN and caregivers' hours are monitored by the GGM monthly and reported to the board. In the reports sighted both caregiver and RN rostered hours exceeded the required hours.</p> <p>Three staff share cooking duties over the week working 6.30 to 3.30 pm. A kitchen assistant works from 7 am to 2 pm and the tea supervisor works 3 pm to 7 pm, supported by another staff member from 4 pm to 6.30pm.</p> <p>Activities/diversional therapy staff currently work Monday to Friday with four staff now employed. There are designated hours for activities in the secure dementia unit each weekday.</p> <p>Four maintenance staff work weekdays across all three KH&VCT ARRC facilities.</p> <p>Five staff work in housekeeping weekdays and three on the weekend. The housekeeping staff rotate between cleaning duties and working in the laundry.</p> <p>In addition, administration staff work weekdays, along with the human resource coordinator. The clinical educator works Monday to Thursday. The clinical educator and human resource coordinator provide services to all three KH&VCT ARRC facilities.</p> <p>There is always at least one RNs on duty with a current first aid certificate. There is at least one RN on duty in the hospital every shift. Staff working in the care home are not responsible for providing any services in the village units except for one resident who is being assisted with lunchtime medications.</p> <p>The clinical charge nurse, the group care manager and eight registered nurses have current interRAI competency. One other RN is currently completing the interRAI training. The RNs are allocated designated time for infection prevention and control, interRAI and other designated activities.</p> <p>There are three volunteers that provide services at a KH&VCT ARRC facility including Kamo Home and Village. These volunteers are all very well known to the management team. The volunteer completes an application form, is approved, sign a privacy and confidentiality agreement, receives an induction /orientation and works under the delegated oversight of a designated employed staff member. The HR coordinator advised the process works well, however, is currently being reviewed.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was completed in the residents' records sampled for review. Clinical notes were current and integrated with general practitioner and allied health service provider records. Any hard copy records or forms are scanned into the electronic system and hard copy records are stored appropriately. This includes interRAI assessments information entered into the electronic database. Residents' records sampled were electronically documented with the name and</p>

<p>uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>designation of the person making the entry identifiable. There is a backup system available for all electronic records. The resident register was now maintained on the electronic system installed. The archive rooms are situated in several localities in locked rooms and records are retrievable if and when needed.</p> <p>Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' admission process into the service is managed by the administrator, general group manager and the clinical charge nurse. The facility brochure is clearly documented, and access processes and entry criteria are communicated to the residents, their family/whanau where appropriate, local communities and referral agencies. Pre-admission forms are completed, and information pamphlets and the facility brochure are provided at the pre-entry stage. Information on all service areas was provided. The family/whanau are involved in the admission process by completing the admission form that provides contact information and in formulating the residents' care plans.</p> <p>All information of prior assessments and Ministry of Health (MoH) authorisation and care levels are scanned or emailed into the electronic system. It is a requirement that all residents are assessed prior to entry to the service. Residents can be directly admitted from other Health Services for Older People or Mental Health Services for Older People from the DHB after relevant full assessment processes and/or specialist referrals have been completed. Enduring power of attorney (EPOA) status is ascertained on admission for all residents and activated for those in the dementia unit if available and with consent.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is a process in place to identify and minimise risks associated with residents' transition, discharge, exit or transfer managed by the clinical charge nurse and the RNs. Discharge or transfer documentation is completed. 'Yellow envelopes' and DHB transfer forms are completed for all transfers to the DHB. Follow up is completed by the clinical charge nurse or RN to ensure safety of the resident (this was observed for the tracer resident in the dementia service on the days of the audit). Documentation was sighted in sampled records. Family/whanau and resident representatives of choice are involved in the transfer process.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that</p>	<p>FA</p>	<p>There are policies and procedures in place that clearly document the service provider's responsibilities in each stage of medicine management. All staff responsible for medication administration had current medication administration competencies conducted by suitably qualified personnel. Medication management training records were sighted. The service has an electronic medication management system in place.</p> <p>There is a policy for medication self-administration that guides staff in the process for safe self-administration.</p>

<p>complies with current legislative requirements and safe practice guidelines.</p>		<p>There was one resident who was self-administering medicines and this person had been assessed as competent to do so by the GP in consultation with the RNs and the clinical charge nurse.</p> <p>Medication was stored safely in the locked medication trollies and medication cupboards in the medication rooms provided in each care setting. The medication is given to residents at regular medication rounds by the nurse or caregiver administering medication. Administration records are maintained electronically. The GP completes three monthly medication reviews and the dates are recorded on the electronic system. No vaccines are stored on-site.</p> <p>Allergies and/or sensitivities are documented on the prescription charts and residents' photos are used as part of resident identification method and these are also dated. Medication fridge temperatures are monitored.</p> <p>The RN was observed administering medication and safe practice that complies with legislation and guidelines was demonstrated. The GP interviewed stated that there have been no significant medication errors in which the GP has been involved. The RNs or the GP link nurse can contact the GP with any queries or points of clarification as needed.</p> <p>There are controlled drugs on site and weekly and six-monthly stock takes were completed in all service areas. Medication was safely stored in locked cupboards. There was emergency stock of antibiotics on site and their use was monitored regularly. There was no expired medication on site.</p> <p>All requirements for pro re nata (PRN) medication and review of short course medications were met.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Catering services are provided at the facility. There are two chefs who were trained in food safety and handling. Food handling training certificates were sighted. Staff have first aid and have completed chemical training as evidenced in the training records reviewed. There is a food procurement process in place that was managed by the chef interviewed and overseen by the group support service manager (GSSM). One chef works four days a week and the other three days are covered by the second chef. They cover each other for leave as needed. A diet profile is completed on admission and whenever there are changes to dietary requirements of a resident and a copy is provided to the catering staff. Food preferences, allergies, likes and dislikes are documented on the diet profile. Special and modified diets are provided when required.</p> <p>The menu plan followed are summer/winter plans and these were reviewed by a dietitian in August 2019.</p> <p>The kitchen was purpose built and newly installed since the previous audit and was observed to be clean and functional on the days of the audit. The fridges and freezers were clean and well packed. Fridge, freezer and food temperature monitoring records were sighted. Interviewed staff demonstrated awareness of infection control measures when handling food. Catering staff were observed to be wearing appropriate protective equipment and adopting appropriate food safety procedures that comply with current legislation and guidelines.</p>

		<p>Interviewed residents/families/whanau reported satisfaction with the food services. Alternative food is offered, and residents are provided with choices. Meals are served at times that reflected community norms. Assistance is offered to the residents when required. Appropriate food is available in the dementia service 24/7 for residents if needed. Residents were observed walking in the dementia unit secure garden with ice blocks on a stick, to help maintain hydration on a hot day. The 'A' grade food control plan is displayed, and the expiry date was sighted as 31 January 2021.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>A process is in place for managing immediate risk to the resident and/or their family/whanau when entry to service is declined and a record is kept. When entry to services has been declined, the resident and where appropriate their family/whanau are advised of the reason for the decline and are given options or alternative services.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Internal risk assessment tools are used to assess the residents' needs, support requirements and preferences on admission. InterRAI assessments are completed in a timely manner. The assessed needs, outcomes and goals identified through the assessment process are documented to serve as a basis for service delivery. Any triggers/outcomes from interRAI automatically appear on the electronic care plan and comprehensive care summaries were reviewed in all residents' records sighted. Assessments are conducted in a safe and appropriate setting as confirmed by the interviewed GP and the GP link nurse. Assessment outcomes are communicated to the residents and/or their family/whanau and referrers and relevant service providers. Electronic documented communication in progress notes was sighted in sampled records.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Residents' long-term care plans and care summary plans were individualised, accurate and up to date. Residents, their family/whanau, diversional therapy staff and care staff are involved in the care planning process. For the dementia level care residents in the secure unit or those with behaviour management issues strategies and techniques for de-escalation are clearly documented and residents are monitored as needed. EPOA are informed and kept up to date with any change in condition or management. The care plans described the required support to achieve the desired outcomes identified by the ongoing assessment process. Service integration was sighted in the sampled residents' records reviewed.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents receive adequate and appropriate services to meet their assessed needs and desired outcomes. Interventions are appropriate to meet the residents' assessed needs and desired outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers and specialist services when required. Referral documents to other services and organisations involved in residents' support were sighted in the sampled files. Interviewed families and residents reported that they were satisfied with the services provided.</p> <p>Interviewed staff reported that there were adequate resources to meet residents' care safely. Adequate resources were sighted onsite and appropriate to the size of the facility and services provided.</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>Activities are planned by the diversional therapists (DTs) and activities coordinators in consultation with the CCN and group care manager. There are weekly activities plans posted on the activities boards that are accessible to residents. The activities provided take into consideration, residents' interests and ability. Residents and their family where appropriate are consulted in the activities assessment and planning process. There is a wide range of activities offered including housie, quiz, music sessions, walking groups, gardening and church services. There is community involvement with external entertainers invited, animal therapy and visits from preschools. There are arranged outings and transport is arranged accordingly. Activities participation is completed daily; documentation sighted.</p> <p>Evaluation of the activities plans are completed regularly by the DTs and the activities coordinators and countersigned by one of the DTs. Daily activities were observed in action in the secure dementia unit at different times of the day and individual activities plans reflect the 24-hour period. Resources are available for staff to access over this time. The activities staff have facilities to store their resources and an office is available shared with the organisation's Chaplain who is very involved with the activities programme and the dementia service support group.</p> <p>Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans and short-term care plans are evaluated in a comprehensive and timely manner. The six monthly, or earlier if applicable, evaluations are resident focused and indicated the degree of achievement of the desired outcome. Where the desired outcome was not achieved, interventions were changed or altered. When acute conditions were resolved, short term care plans were signed off or closed. The comprehensive care summaries were continually updated to guide care staff.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are referred to other health and disability service providers when required. Referral documents were sighted in the sampled records. The clinical charge nurse, RNs, GP link nurse and the GP are involved in the referral process in consultation with the residents and/or their family where appropriate. Informed consent, general consent forms and referral documentation was sighted in sampled residents' electronic records (forms can be printed off if required). Residents and/or their family are advised of their choice to access other health and disability services where indicated.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. All cleaning, laundry, maintenance and kitchen staff have completed training in the safe handling of chemicals. An external company is contracted to supply all chemicals and cleaning products and they also provide relevant training for staff. The chemical provider has recently changed. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of appropriate protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry 01 June 2020) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with the group support services manager (who is responsible for the maintenance personnel), as well as observation of the environment. The environment was hazard free, residents were safe, and independence was promoted in all areas including the dementia unit.</p> <p>There are 15 bedrooms in Shelagh Mason House for the provision of hospital level care. The secure dementia unit is also known as Alice Court and contains 24 beds. Tuatara Court contains ten studio units, of which three units are now used for the provision of either rest home or hospital level care. Tuatara Court is attached to the other care home units. Wings one and two each contain ten beds. All residents' bedrooms are single occupancy except for the three studio units, located in Tuatara Court. These three units can be used for the care of up to two residents that require either rest home or hospital level of care. Two of these studio units had</p>

		<p>previously been approved for dual occupancy. This audit included verification that a third studio unit in Tuatara Court was a suitable for providing rest home or hospital level care for up to two residents. This room has enough space, call bells are present at each bed and a portable privacy screen is available for staff to use when required during residents' personal cares.</p> <p>External areas were safely maintained and appropriate to the resident groups and setting. There is a secure appropriate garden area accessible to residents living in the secure dementia unit.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy with the environment.</p> <p>The kitchen has been totally renovated with a purpose-built kitchen now installed. Refurbishing work has been undertaken in the dementia unit. This included painting murals on/around the internal doors leading out of the unit and replacing the larger viewing holes with peepholes. Staff advised this has been very effective in reducing the residents wandering/waiting in this area checking the doors, looking for a way out.</p> <p>All the facility vehicles have a current registration and warrant of fitness and this is monitored monthly.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 14 toilets and 11 showers that are for general use. There are four rooms/units with full ensuite and separate staff and visitors' toilets. The ablutions in the dementia unit have been repainted with different coloured doors to help identify the bathrooms, and were safe with no accessible chemicals, and afforded privacy. Hot water temperature monitoring of the water outlets accessible to residents occurs on a rotating basis with testing occurring at least monthly. The records sighted showed temperatures at or below 45 degrees Celsius. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are three studio units that have two residents (spouses) in each unit otherwise all bedrooms are single occupancy. There were no shared rooms in the dementia unit and each room was individualised to assist residents in identifying their own bedroom. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported their</p>

consumer group and setting.		bedrooms are suitable for their needs.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. The kitchenette servery area in the dementia unit was secured to prevent unauthorised access for confused people. The dining areas in this unit were clearly identifiable and the observed mealtimes were unhurried, calm and conducive to stress free dining. Residents can access areas for privacy, in all areas of the home including the dementia unit if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site seven days a week by nine staff who work as housekeepers rotating between providing cleaning services and working in the laundry. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry services for all three of the KH&VCT aged related residential care facilities are provided on site with a daily drop-off of clean linen and collection of soiled linen occurring for each facility. Clean linen is stored in a separate area of the vehicle from that used to transport soiled linen.</p> <p>Each member of the housekeeping team has attended suitable training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The family members interviewed for residents in the dementia unit expressed satisfaction with cleaning and laundry services provided. These areas were observed as clean and staff were vigilant with ensuring cleaning chemicals or equipment were not left unattended. Cleaning and laundry processes are monitored through the monthly quality check (internal audit) and resident satisfaction survey programme. A register is maintained of all chemicals available on site, the quantity and location.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 9 September 2008. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent fire drill occurred earlier in the week of audit. The orientation programme includes fire and security training. Staff in all areas including the dementia unit, confirmed their awareness of the emergency procedures. Each individual residents' level of assistance,</p>

<p>and security situations.</p>		<p>as required in the event of an emergency is noted in the resident's electronic records.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, clinical and other consumables, stationary, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents (72) and the water storage requirements for the region. There are four water tanks containing a total of 7000 litres of water located on site. A generator has been installed in the last 18 months, and functioning is tested monthly. The group support services manager advised this could keep the facility functioning effectively in the event of an emergency for over a week.</p> <p>Call bells alert staff to residents requiring assistance. These alert audibly as well as with a light illuminating outside the applicable room and onto a centralised alert panel. Residents and families reported staff respond promptly to call bells, in all areas and this was observed during the audit.</p> <p>Appropriate security arrangements are in place. There are security cameras monitoring internal communal areas and entry points. Signage alerts that these cameras are in use. Doors and windows are locked by staff at a predetermined time. Images are retained for a designated period and are accessible only to approved personnel. There are staff duress alarms installed throughout the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. All bedrooms have natural light, opening external windows and some have doors that open onto outside areas. Heating is provided via electricity / radiator panels in most residents' rooms and communal areas. Underfloor heating is used in the studio units in Tuatara Court. The group support services manager advised the temperatures of the radiators is controlled centrally for safety. Areas were at an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature all year round.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>	<p>FA</p>	<p>There is an infection control programme which minimises risk of infection to residents, staff and visitors. The infection control programme is led by the GGM and reviewed annually; documentation was sighted. The GGM monitors all infections, uses standardised definitions to identify infections appropriately, and carries out surveillance monitoring of organisms, related to antibiotic use. Monthly records sighted are maintained. Infection prevention and control is presented at each staff meeting and was sighted in meeting minutes. The programme was appropriate to the size and nature of the service. The infection control policies and procedures clearly defined the responsibility of infection control coordinator role and there were clear lines of accountability for infection control matters in the organisation leading to the senior management team.</p> <p>There were infection control posters and disinfection agents throughout the facility to increase awareness to</p>

scope of the service.		residents, staff and visitors on prevention and minimising spread of infections. Staff, residents and visitors who are infectious or exposed to infection are prevented from exposing others while infectious.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There is adequate human, physical and information resources to implement the infection control programme that meets the needs of the organisation. The infection control coordinator is the GGM and a CCN assists the process. Both have access to expert advice from the local DHB and the GP to achieve the requirements of this Standard. Interviewed staff reported that they have adequate infection control resources to observe appropriate infection control measures. The committee meets three-monthly. The organisation is a member of an infection control organisation which provides excellent reference material for staff to utilise and to guide staff as necessary. Guidelines and a pandemic plan are in place should an incident arise.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are written policies and procedures for prevention and control of infection which comply with relevant legislation and current accepted good practice. The policies and procedures were practical, safe and appropriate for the type of services provided. The infection control policy and procedures folders were accessible to all staff. The infection control job description was in place. Specific infection control areas, such as surveillance, wound-care management, blood and body spills, cleaning and disinfectant were covered adequately. Standard precautions are adhered to throughout all areas of service provision.</p> <p>Observations at the onsite audit identified implementation of infection control procedures. Staff demonstrated safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support</p>	FA	<p>Relevant education on infection control is provided to all staff at orientation and annually by the infection control coordinator and CCN. Infection control training records were sighted. The GGM and the CCN both completed relevant training for the roles in 2019 as per the training records and verified at interview. Infection control training records were maintained by the GGM. When interviewed, the infection control coordinator, the CCN involved with infection prevention and control and caregivers demonstrated knowledge on the infection</p>

staff, and consumers.		<p>control procedures that comply with current legislative requirements.</p> <p>Residents' education is provided in a manner that meets the residents' communication method or style. Documentation was sighted in the electronic care plan summaries for any residents with acute infections.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The GGM has managed and maintained all infection prevention and control records since 2011 until the present time. The infection prevention and control surveillance that is undertaken is appropriate to the size and scope of this aged care setting as demonstrated in the infection control programme. All staff are involved. The staff report all signs and symptoms of infection for residents and the CCN follows this up. Monitoring is described in the infection control plan to describe actions to ensure residents' safety. Any identified infections, treatments underway are discussed at the handover between shifts. Staff interviewed stated they were kept well informed of any changes due to infections and this was also updated on the care summaries.</p> <p>Reported infections are collated in the monthly surveillance and analysed by the GGM by infection type, such as urinary infections, skin tears, wounds, gastro-intestinal, respiratory and ear, nose and throat infections. All records across the organisation's three ARRC sites were collated together in the quarterly report reviewed. When analysed, any risk trends can be identified in the electronic system used. The monthly analysis included comparison with the previous month, reasons for an increase or decrease of infections and action taken is reported to staff at the quality/staff meetings. Graphs and evidence summaries are provided for the staff and were displayed in different settings around the facility. National and international benchmarking occurs, and records were sighted. The infection rate for the organisation is low as per the size and nature of the three services provided at Kamo Home and Hospital.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures (last reviewed and updated in January 2020) meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Enablers are only used when competent residents request to aid freedom of movement. The use of enablers was noted in the applicable sampled residents' care plans and assessments. The restraint coordinator is the group general manager who provides support and oversight for enabler and restraint management in the facility. Staff interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. Training on the use of restraint and enablers is included in the orientation and ongoing education/staff competency assessment programme.</p> <p>There were no residents using restraints and nine residents were using enablers on the days of audit. The restraint register and staff interviews confirmed there have been no restraints used since 2018 when there were 17 residents that had restraints used. The organisation uses a range of other interventions to actively avoid the use of restraint and is pleased to have been restraint free for over 12 months. Restraint is only used as a last resort when all alternatives have been explored as verified by staff and managers interviewed. Refer</p>

		to the area of continuous improvement raised in criterion 1.2.3.6
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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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service provides an environment that encourages good practice which is evidenced practice in all areas of service delivery. In the secure dementia service 'Alice Court' families/whanau are always welcome to visit as frequently as able to see their loved ones within the service's care. The trained staff are able to answer any questions they may have; however, this was seen as not always adequately meeting the needs of the family/whanau as many had been looking after their relative for some time at home prior to requiring admission to the service and that 'letting go' was very difficult for family/whanau members interviewed. A team was established, and the support group was formed. The chaplain speaks with each family and at an appropriate moment introduces the support group. Once a date is set for the next group meeting all new families are invited to meet with individuals who have a loved one in care with</p>	<p>Having fully attained this criterion, the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on the findings and improvements to an area of service delivery. The Group Care Manager (GCM) and staff have received significant responses of satisfaction from families/whanau and those with enduring power of attorney (EPOA) since implementation of the Alice Court support group set up for families/whanau of residents in the secure dementia service. Families/whanau are always welcome to visit but the experience of admitting a relative into the unit can be very difficult and traumatising for all concerned. In order to increase the support offered already a support group has been formed with past and present family members and the organisation's chaplain. The group is informal and provides a safe and supportive forum for families to talk through their concerns. Positive feedback has been received from family</p>

		whom they can chat with 'special understanding'. Support and friendships have been built from this group and are ongoing. Families interviewed spoke highly of the support received through the meetings and from staff.	members and the chaplain. The chaplain stated that these groups provide her with a higher level of understanding around new residents and their family which allows the chaplain and staff to provide better long-term care and outcomes to benefit the residents and families.
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The results of the monthly quality checks (internal audits) are grouped together with other relevant components as determined in a matrix, and the amalgamated results are reported in five different categories (matrix of care – clinical, matrix of care-process, matrix of support, matrix of business – process and matrix of business – financial), as part of the balance score card to the management team, staff and the board of trustees. The service has reviewed these processes in the last 12 months with a focus on identifying system and process improvements rather than being reactive or responding with a negative or punitive focus. Staff and managers interviewed spoke positively about the changes. Staff are actively encouraged to offer their suggestions on any improvements that can be undertaken to both systems and processes. This has fostered a culture of inclusiveness with everyone's contribution to the quality and risk process valued.</p> <p>In addition, a range of quality data is benchmarked quarterly with other facilities in Australia and New Zealand. Reviewing the results of the benchmarking programme, as well as the internal quality review data and incident data have resulted in a range of initiatives and interventions occurring. These interventions/initiatives have resulted in a reduction in falls with and without injury, pressure injuries and the use of restraint.</p>	Active review and analysis of quality improvement data has resulted in a significant reduction in the number of resident falls both with and without an injury, pressure injuries and the use of restraint. Interventions included (but were not limited to), the introduction of non-slip socks, introduction of sensor chair pads, earlier identification of residents moving, the commencement of a falls prevention group, socialisation of high risk residents promoting increased visibility, rostering additional staff, purchasing additional pressure reducing mattresses and cushions, ongoing staff education, and the introduction of primary caregiver roles increasing staff accountability and engagement. There has been a reduction in falls with injury from 50 in 2018 to 39 in 2019, falls with no injury has reduced from 177 in 2018 to 135 in 2019, and the number of pressure injuries has reduced from 24 in 2018 to seven in 2019. In addition, the service went from having 17 residents with restraints in use in 2018 to nil in 2019/2020 year to date.
<p>Criterion 1.3.3.1</p>	CI	Each stage of service delivery is undertaken by suitably qualified and/or experienced staff who are competent to perform the function for their area of service provided.	Having fully attained this criterion, the service can in addition clearly demonstrate a review process including a satisfaction survey, analysis and reporting of findings, evidence of action

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>		<p>The service is well supported by a medical centre with a nominated GP who visits weekly accompanied by the local pharmacist and a locum pharmacist from the DHB. Previously the CCN or one of the RNs on duty accompanied the GP on the rounds. A proposal was discussed between the GCM and the GGM to introduce the GP link nurse to increase continuity of service delivery. The role and job description was outlined in detail as to the functions and responsibilities. The role was widely advertised before an appointment was made. The link nurse is very experienced as a general nurse and has extensive palliative care knowledge. The rostered days are planned to cover and implement the many facets of the role. This role is fully supported by the GP, RNs, management and is well recognised by the referral agencies as was confirmed by a visiting community nurse who was interviewed during the audit. The GP and community nurse provided positive feedback about the service delivery provided at this home and hospital.</p>	<p>taken based on those findings and improvements to service provision and resident's health, wellbeing, safety and satisfaction as a result of the review. The implementation of the GP link nurse role has provided an additional level of continuity of care, efficiency and management for the residents within this facility. The registered nurse team have expressed they also feel supported by the GP link nurse and work collaboratively for improved outcomes for the residents. Families/residents have expressed satisfaction with this role and appreciate knowing that they have the same nurse with the GP for visits. The GP interviewed is assured the one RN/contact has improved efficiency and response times between the medical centre and the facility with the practice nurses also being able to have one identified contact in the form of the GP link nurse. The GCM, CCN and link nurse meet regularly to discuss or identify any areas that may enhance the role further.</p>
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End of the report.