

North Waikato Care of the Aged Trust Board - Kimihia Home & Hospital

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:	North Waikato Care of the Aged Trust Board
Premises audited:	Kimihia Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 December 2020 End date: 8 December 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	76



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kimihia Home and Hospital provides rest home, secure dementia care and hospital level care for up to a maximum of 77 residents. The total capacity has reduced by one bed since the previous surveillance audit in August 2019.

Day to day services are overseen by a facility manager (FM) who is a registered nurse (RN) and clinical nurse managers (CNMs). The facility manager advised the most significant changes to the service was the departure of one clinical nurse manager a month previous to the audit and the second clinical nurse manager has resigned and was due to leave the week after this audit was conducted.

This re-certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the board chairperson, facility manager, clinical nurse manager, care staff, a contracted physiotherapist, and a general practitioner.

Six new findings identified during this audit relate to the condition of some residents' bedrooms, the security of the fence outside the dementia wing, laundry services, development of initial care plans and updating of long-term care plans when a resident's condition changes, annual review of the infection control programme and a comprehensive quality review and evaluation of restraint activity. Two of these findings were rated moderate risk, the other four were rated low risk.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

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

Services at Kimihia Home and Hospital are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in courteous and respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori 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.

Open communication between staff, residents and families 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 services provided to residents are of an appropriate standard.

A complaints register is maintained and there was evidence that complaints are acknowledged, investigated and resolved promptly 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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data which identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and these were current.

The appointment, orientation and management of staff is based on good employment practice. A systematic approach to identify and deliver ongoing training to staff supports safe service delivery. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated electronic and hard copy files.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Kimihia Home and Hospital works closely with the local Needs Assessment and Service Co-ordination 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. Shift handovers and communication sheets guide continuity of care.

Long term 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 arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is provided by a diversional therapist and two entertainment officers. The programme provides residents with a variety of individual and group activities. A facility van is available for outings.

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

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The buildings, plant and equipment are in a safe condition. There is a current building warrant of fitness and approved evacuation plan. All areas are spacious and suitably furnished.

External areas are accessible for all residents. There were no physical restrictions/locked doors in the hospital or rest home areas.

Each resident's bedroom had at least one opening window for natural light and adequate ventilation. Residents decorate their rooms with personal effects and the facility provides a home like atmosphere. Electric panel heaters are fixed to the wall in bedrooms allowing for individual choice of heat settings.

Trial fire evacuations are held six monthly in all wings and staff attend ongoing education and training in emergency management. Emergency egress and fire suppression services are checked regularly by maintenance staff and an external service. The facility has a fully equipped civil defence kit and sufficient stored water.

Laundry services were being outsourced with the exception of some resident's personal laundry and cleaning cloths. The part time laundry person and cleaning staff have attended training in chemical safety.

A designated smoking area is available for residents who require this.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The organisation has implemented policies and procedures that support the minimisation of restraint. On the days of audit there was one resident using a voluntary enabler and four residents who required bedrails or a fall out chair as restraints, to keep them safe from harm.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control programme, led by a trained infection control nurse, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the Waikato District Health Board.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken. Data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	3	2	0	0
Criteria	0	95	0	4	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Kimihia Home and Hospital (Kimihia) has policies, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information. A concern expressed by a family member at audit, was verified with the facility manager (FM) and through the complaints process (refer 1.1.13). This has subsequently been addressed.</p> <p>All residents in the secure unit had an activated Enduring Power of Attorney (EPOA) in place.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the</p>

		<p>resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day-to-day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents and residents' family members are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were also displayed in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family. Because of the Covid-19 risks to the residents, community links have not been maintained at Kimihia since March 2020. Van outings occur; however, residents are not able to get out of the van. Outings to cafes and community events have been temporarily stopped, as have visits by community groups. A week prior to audit, church services have commenced on a Sunday, however only two church staff are permitted onsite to provide the service. Visiting hours remain restricted. An interview with the FM verifies these restrictions remain in place and will be reviewed in the New Year.</p> <p>Family members 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>	FA	<p>The complaints policy and associated forms comply with Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to raise concerns or complaints.</p> <p>The complaints register and associated documents reviewed showed that nine complaints received this year had been fully investigated, and actions were taken through to an agreed resolution within acceptable timeframes by the FM who is responsible for complaints management and follow-up. An additional complaint about the FM to the Board has been investigated and is waiting for response and resolution by the Board for closure.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There had been no known complaints to the DHB or Office or the Health and</p>

		Disability Commission at the time of this audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members of residents, when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in common areas around the facility. Brochures on advocacy services, how to make a complaint and feedback forms, are located at reception and near the nursing stations.</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 the services they receive from Kimihia are provided 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, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussion with families and the GP. There are four x four bedded rooms plus single rooms in the hospital. The four bedded rooms have curtaining that ensures residents' privacy. Small lounges are located throughout the facility that enables residents' privacy during conversation.</p> <p>All residents in the rest home and secure unit have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a</p>	FA	<p>There were fourteen residents and forty staff in Kimihia at the time of audit who identify as Māori. Observations and interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Several staff were</p>

<p>manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>observed speaking to residents in te reo Māori. The Māori news was on one of the television sets in the rest home, for residents to watch if they chose to.</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>	<p>FA</p>	<p>Residents and family members of residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are 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>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, the diabetes nurse specialist, physiotherapist, wound care specialist, community social workers, and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support to access external education, through the Waikato District Health Board (WDHB) and online learning hubs to support contemporary good practice. Two of the activities staff had attended a two-day diversional therapy training programme in Auckland earlier this month. They also have access to online 'webinars' through the organisation's membership with the diversional therapy society. Internal training sessions</p>

		occur within the facility.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>During the Covid-19 lockdown, communication with residents and families was enabled using emails, telephone and social media messaging through a private online space.</p> <p>Interpreter services can be accessed via the WDHB when required. Staff knew how to do so. Staff reported interpreter services were rarely required due to several multiracial staff members being available who could speak in the residents' languages.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>A current strategic plan outlines the purpose, values, scope, and direction of the service and includes annual and longer-term objectives which link to operational plans. Interview with the board chair and FM and review of meeting minutes confirmed that business goals and other operational matters are discussed at monthly board meetings.</p> <p>The FM is a registered nurse (RN) with relevant qualifications. This person has been in the role for three years and has long term experience employed as an RN in aged care facilities. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>Interviews confirmed the FM is knowledgeable about the sector, regulatory and reporting requirements and maintains currency through meetings with other aged care providers at DHB meetings and liaison with facility managers in the Community Trust Care Association (CTCA) group. CTCA is a business entity comprising nine aged care facilities who share common factors, such as being located rurally and governed by not-for-profit organisations. Membership with CTCA continues to add value and business improvements through bulk purchase arrangements, shared staff training and the regular peer support groups for activities staff, RNs, board members and carers. This group had recently negotiated a beneficial group insurance scheme.</p> <p>Kimihia holds agreements with the DHB for age related residential care (ARRC) in rest home, dementia, hospital medical and geriatric care, respite and palliative care, Long Term Support-</p>

		<p>Chronic Health Conditions (LTS-CHC) and the Ministry of Health (MoH) for Young People with Disabilities (YPD).</p> <p>On the day of audit 76 of the 77 beds were occupied. Thirty-nine residents were receiving rest home level care (one of these was on short term respite and one person was had been admitted for post-acute care (PAC) via the DHB. Twenty-five residents were receiving hospital care, which included one palliative care person and an ACC funded person and there were 12 residents in the secure unit, one of these was for short term respite. There were no residents under the age of sixty-five years.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Discussions with the FM, CNM and other staff confirmed that temporary cover during the FMs planned absences is delegated to the CNM and the board accountant/ administrator. Staff stated these arrangements were proven to be effective and ensured continuity for staff, residents and their families. The FM had not planned any leave until a new management structure is in place. An additional experienced senior RN has commenced employment and the FM has suitable interim and long-term plans to provide sustainable clinical leadership.</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>	FA	<p>The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. Their membership with CTCA includes shared policies and procedures and benchmarking between the nine facilities. The FM collates and analyses all incidents before submitting data for falls, urinary tract infections (UTI's) skin tears and pressure injuries for comparative benchmarking. Interview with the FM and review of staff meetings minutes confirmed that data for all incidents, infections and restraint is reported and discussed monthly.</p> <p>There was evidence of progress toward achievement of the three quality objectives cited in the 2020 quality plan. For example, improving staff compliance with manual handling, improving health and safety outcomes, and improvements to the call bell system. Other continuous quality activities are conducting regular resident and family satisfaction surveys and meeting with residents monthly. Outcomes from quality monitoring is reported verbally and in written formats to all staff and the board. Where areas for improvement are identified these are documented and actions are monitored for implementation. Previous methods for monitoring the standard of service delivery, such as internal audits, were under review by the FM who described strategies to be implemented in the New Year that involved a wider range of staff.</p> <p>More in-depth discussion of quality data and service provision information occurs at monthly meetings of the health and safety committee, and at the RN meetings which always includes</p>

		<p>review of infection control, and restraint matters. Staff reported their involvement in quality and risk management activities through training and information shared at meetings. The manager notifies all staff of corrective actions or policy/process changes by memos and verbally at meetings. Review of the most recent (March 2020) resident and family satisfaction surveys revealed dissatisfaction with laundry services, all other areas were rated as moderate to high satisfaction. An improvement is required in standard 1.4.6 regarding laundry services.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>There is a current risk management plan which is monitored by the FM and the Board. The manager is familiar with the Health and Safety at Work Act (2015) and described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. There had been no notifications to WorkSafe since the previous audit.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed for 2020 revealed clear descriptions of the event, and that incidents are notified and reviewed in a timely manner. All incident and accident events were being reviewed and investigated by the CNM and the FM, and where necessary actions to prevent recurrence had been implemented. Adverse event data is collated and analysed for trends in statistical and narrative formats before being reported to the board and all staff. Falls, urinary tract infections, skin tears and hospital admissions are benchmarked with the eight other facilities who belong to CTCA. Kimihia's rates for falls and hospital admissions compare favourably. Falls prevention was an area of continuous improvement at the previous audit.</p> <p>The manager reported that Section 31 notifications to the Ministry of Health and the DHB had occurred for changes within the board and the recent resignation of clinical nurse managers. There had been no police investigations, coroner's inquests, or issues-based audits.</p> <p>The DHB manager for health of older persons, gerontology nurse specialist and public health unit had been informed by the FM about a potential scabies outbreak in September 2020. The public health unit confirmed this was not notifiable under the Public Health Act. Scabies had since been confirmed in October and a visiting dermatologist on day one of audit, confirmed no active cases but mitigation measures were still in place to prevent re-infection.</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 recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of nine staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation followed by an initial performance review.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff are encouraged to study toward a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Records reviewed demonstrated that 14 of the 42 caregivers have completed level four of the National Certificate in Health and Wellbeing, ten care staff have achieved level three and one person had achieved level two. There were 17 staff who have no qualifications, four of whom are on a higher pay band for length of service. The staff rostered to work in the dementia care area have either completed, or are enrolled to achieve, the prerequisite unit standards in dementia care.</p> <p>Each of the staff records reviewed contained evidence that a performance appraisal had occurred within the past year and that all new staff attend orientation.</p> <p>Five of the eight RNs employed are maintaining annual competency requirements to undertake interRAI assessments. The FM had completed interRAI training but not maintaining competency and has management access. Active recruitment for experienced RNs and a clinical nurse manager is underway.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented 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 after-hours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of the three-month roster cycle confirmed adequate staff cover has been provided for the number of residents and their needs. The part time staff or agency personnel are used to replace staff unplanned absences. Agency staff were on site on average three times a week.</p> <p>All RNs have a current first aid certificate including CPR and there is always an RN on site.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</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 enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the FM or the clinical nurse manager (CNM). They are also provided with written information about the service and the admission process. All residents have authorisations in their file to verify the placement in each of the three areas has been approved.</p> <p>Residents in the secure unit have activated EPOAs in place, and an admission agreement signed by the EPOA.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.</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>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the WDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned</p>

		and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a recently implemented electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There were four residents who self-administer inhaler medications at the time of audit. Appropriate processes were in place to ensure this is managed safely.</p> <p>Medication errors are reported to the RN, CNM and FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>dietitian on the 8th of August 2020. Recommendations made at that time have been implemented.</p> <p>The facility has an up-to-date food control plan in place verified by the Waikato District Council on the 4th of July 2020. This expires on the 4th of July 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Residents in the secure unit have access to food any time of the night and day.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</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>	<p>FA</p>	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>On admission, residents of Kimihia are initially assessed using a range nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment</p>

manner.		<p>data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed, initial assessments were completed as per the policy and within 24 hours of admission. Except for the respite clients' files, interRAI assessments are completed within three weeks of admission and at least six every months, unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Residents in the secure unit have behaviour management plans and behaviour monitoring sheets in place.</p> <p>Apart from those referred to in criterion 1.3.3.3, care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Except for those files referred to in criterion 1.3.3.3, documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
Standard 1.3.7: Planned Activities	FA	The activities programme is provided by a trained diversional therapist and two entertainment

<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>officers. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal three/six monthly care plan review.</p> <p>Residents in the secure unit have activities plans in place that address residents' twenty-four-hour needs.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals and ordinary patterns of life. Individual and group activities and regular events are offered (eg, craft sessions, bowls, exercises, word games). The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted whereby short-term care plans were consistently reviewed for infections, pain and weight loss, and progress evaluated as clinically indicated. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<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</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the</p>

choice/needs.		circumstances dictate.
<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.</p> <p>Cleaning chemicals are stored securely when not in use and decanted into labelled containers. An external company is contracted to supply and manage all chemicals and cleaning products and provide information about each to staff. 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 ample provision and availability of protective clothing and equipment and staff were observed to be using this. Covid precautions, such as visitor temperature screening and declaration and mask wearing, were in place on the days of audit.</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>	PA Moderate	<p>A current building warrant of fitness with expiry 31 March 2021 was on display.</p> <p>Routine systems are in place to ensure that the 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 maintenance personnel and observation of the environment. Both vehicles were road worthy and well maintained.</p> <p>External areas accessible to rest home and hospital residents are appropriate for that group and well maintained for safety. The perimeter fence outside the secure unit requires modification, for example additional height to deter residents from trying to scale it. (Refer criterion 1.4.2.6)</p> <p>Residents and staff knew the processes to follow if any repairs or maintenance were required and said that requests were actioned promptly. All internal environments are home like and spacious. There is a requirement to refurbish five bedrooms in Totara wing (refer criterion 1.4.2.4)</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities.</p>	FA	<p>There were sufficient numbers of accessible bathroom and toilet facilities throughout the facility for the 77 residents. Thirteen rooms have ensuite bathrooms. There were four shower rooms in the hospital for 22 residents and four showers in the rest home for 26 residents, plus another two shower rooms for nine residents in the dual-purpose wing. The dementia unit had two shower</p>

<p>Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>rooms and three clearly identified toilets for a maximum of 12 residents. There were five staff and visitors' ablution areas located throughout the building.</p> <p>Appropriately secured and approved handrails were provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water temperature monitoring occurs monthly in all areas. Records of these showed that temperatures do not exceed 45 degrees Celsius.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All but four bedrooms in the hospital wing provide single accommodation. Residents are encouraged to personalise their rooms with their own furnishings and memorabilia.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents were happy with the size of the bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There were four lounges, dining and activity areas located throughout the building, all within easy access for residents. Residents from a range of wings were observed attending activities in the main lounge. There is a chapel on site. The hospital wing and secure unit have their own lounge and dining areas.</p> <p>Residents and family members interviewed expressed satisfaction with the layout of the facility and communal areas.</p> <p>Residents were observed to be mobilising independently to utilise all areas within the facility on audit days</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>PA Low</p>	<p>Cleaning services are safe and monitored for effectiveness via daily inspections and by the external chemical provider.</p> <p>The bulk of laundry is processed off site and had been outsourced since 2018. A laundry person is designated four hours a day to oversee the system, and sort and return residents' personal clothing to them when it comes back from the contracted laundry service. Respite residents' personal laundry and cleaning cloths are laundered on site. Policies and procedures for cleaning and laundry clearly described processes for safety and hygiene. Staff interviewed confirmed their knowledge and understanding of procedures.</p>

		<p>Family members, staff and residents interviewed expressed dissatisfaction with laundry services. This was substantiated by negative feedback in the March 2020 satisfaction survey and complaints lodged about loss and damage to personal clothing. There is a requirement in criterion 1.4.6.2 to improve laundry services.</p> <p>Cleaning and laundry staff are on site seven days a week for enough hours to complete the tasks allocated each day. There are designated areas for secure storage of cleaning and laundry chemicals. Training records and staff interviews confirmed ongoing education about safe handling of chemicals is provided. There had been no incidents of harm related to chemicals reported.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Onsite inspection and interviews revealed that the emergency and security systems are intact and known by all levels of staff. Fire safety and evacuation are included at orientation and six-monthly fire evacuation drills occur. There was a current approved fire evacuation scheme dated 2009.</p> <p>Interview with the FM and maintenance staff and inspection of the emergency/civil defence stores confirmed there was sufficient stock of water, food, equipment and essential supplies in the event of a natural disaster. There were large tanks of accessible water on site which meets the recommendations set for the region by the Ministry of Civil Defence and Emergency Management. All buildings are fitted with emergency back-up lighting and an onsite generator initiates automatically in the event of power outage.</p> <p>A new call bell system was installed in the rest home, dementia and dual bed wings in 2020.</p> <p>Staff routinely lock entry doors at dusk and the site is security patrolled during the night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All areas inspected were light, airy and at a comfortable temperature on the days of audit. Each room has at least one opening window and all bedrooms have the ability to adjust the amount of heat being radiated by the central heating system or by heat pumps. There had been no concerns raised about the internal winter or summer temperatures. Residents interviewed said they were comfortable in their rooms and in the communal areas.</p>
<p>Standard 3.1: Infection control management</p>	PA Low	<p>The service provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>control manual, developed at organisational level with input from the CNM. The infection control programme has not been reviewed annually, and this requires attention.</p> <p>The CNM at Kimihia is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM, and tabled at the board, staff, and RN meetings. Infection control statistics are entered in the organisation's electronic database. The incidence of urinary tract infections is benchmarked within the group's other facilities.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control co-ordinator (ICC) has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken training in infection prevention and control, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisory company is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and FM confirmed the availability of resources to support the programme and any outbreak of an infection.</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>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last two years and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan.</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent scabies outbreak and the Covid-19 restrictions.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC and FM reviewed all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Urinary tract infection data is benchmarked internally within the group's other aged care providers.</p> <p>A recent scabies outbreak at Kimihia, has taken a while to get under control. The advice of the WDHB, Public Health and specialist services has been used. Analysis of the outbreak has occurred and changes to practice will ensue going forward. The extended period of the outbreak was because of Covid-19 precautions by a number of external service providers (ie, specialist services).</p> <p>A good supply of personal protective equipment is available. Kimihia has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>standards. These provide guidance on the safe use of both restraints and enablers. A senior RN is the designated restraint coordinator. This person provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding her role and responsibilities and the organisation's policies and procedures.</p> <p>On the days of audit, three hospital residents were using bedrails as restraints, one required a fall out chair and one rest home resident had a bedrail being used voluntarily at their request as an enabler. The same processes for assessment, consent and monitoring are followed for the use of enablers and restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the clinical files and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint coordinator and GP are responsible for approving the use of restraints and overall restraint processes. Residents' files and interviews with the coordinator confirmed there are clear lines of accountability, that all restraints were approved before use, and that the overall use of restraints was being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented to the level of detail required in this standard. An RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The CNM interviewed readily described all aspects of the assessment process. Families interviewed confirmed their knowledge and involvement in the process. The general practitioner is involved and makes the final decision on use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in each of the clinical records for the residents who were using a restraint and bed rails as an enabler.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the CNM described how alternatives to restraints are discussed with staff and family members (for example, the use of sensor mats, and low</p>

<p>Services use restraint safely</p>		<p>beds).</p> <p>When restraints are in use, regular monitoring occurs to ensure the resident remains safe. The monitoring records contained all expected and necessary details. Access to advocacy is provided if requested and processes to ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each RN meeting. The register accurately recorded all residents currently using a restraint and sufficient information to provide an auditable record (for example, the type of restraint, date of commencement, and date for review or when it was stopped).</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews and at RN meetings. Families interviewed confirmed their involvement in the evaluation process and said they were happy with the restraint process.</p> <p>The evaluation covers all requirements of this standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and that documentation was completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>PA Low</p>	<p>The use of restraint use is reported at RN, health and safety and general staff meetings, as evidenced by interviews with RNs, the CNM and FM and review of meeting minutes. Although individual restraints are reviewed at least six monthly, there has not been a formal quality review of restraint practice for more than 18 months.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>Seven of the nine files reviewed were of long-term residents of Kimihia. No initial care plans were sighted in these residents' files. The other two files were of two new residents who had been in the facility for less than three weeks and had no long term or initial care plan in place to guide the nursing care required to be provided to these residents. An interview with the CNM identified there was no document at Kimihia to manage this process. No residents admitted to Kimihia had an initial care plan in place within twenty-four hours of admission. Discussion with the FM resulted in the document being accessed.</p>	<p>Residents of Kimihia have no initial care plan in place within twenty-four hours of admission. Residents' care plans are not consistently updated in a timely manner to reflect residents' changing needs.</p>	<p>Provide evidence all residents have an initial care plan completed within twenty-four hours of admission. Provide evidence that care plans are updated in a timely manner to reflect any change in care needs.</p>

		<p>In addition, two of the seven long-term residents' files verified the care plans had not been updated to reflect the residents' changing needs. One resident now required a palliative approach, with a change in approach to a range of needs which was not documented. This was addressed at the time of audit, with a GP review, involvement of family, hospice consultation and the care plan updated. The second file required a documented update regarding the behaviour management strategies of a resident with a range of complex personality problems, and a recent choking event.</p> <p>Interviews with the staff verified care provided to these residents was as per verbal handovers and daily RN oversight.</p>		30 days
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>All areas in the home were safe and promoted mobilisation and residents' independence.</p> <p>Five bedrooms in Totara wing (rest home) were particularly shabby with peeling wallpaper, and the vinyl floor in bedroom 10 had lifted and posed a trip hazard. Interior decorating was previously thwarted by the limited number of hours allocated for maintenance personnel. There is now a full time employed staff member available to carry out interior work.</p> <p>Each of the bedrooms in this wing had wash basin vanities constructed of 'MDF' board which makes the surfaces</p>	<p>Bedrooms 4, 5, 6, 8 and 10 in Totara wing, require repair/refurbishment of the wall surfaces. Bedroom 10 also requires repair to the floor surface and the vanity unit.</p>	<p>Conduct redecorating of wall surfaces and repairs to the floor and vanity unit of bedroom number 10.</p> <p>90 days</p>

		<p>susceptible to water damage and compromises hygiene. Two family members interviewed were displeased with the appearance of these rooms.</p> <p>The FM and board chair interviewed said there were plans to renovate this wing to create shared ensuite bathrooms between two rooms, which is likely to take longer than is desirable.</p>		
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA Moderate</p>	<p>There are plenty of pleasant external areas for residents which are safe and accessible. These contain safe walkways, gardens, shading and suitable seating and tables.</p> <p>The perimeter fence outside Kauri wing secure unit, poses a climbing temptation and subsequent risk to the residents who have access to it. The five-and-a-half-foot high fence appears scalable as demonstrated by a resident who recently attempted to climb it. There is always a staff member in the unit and an alarm bell activates when people pass through the door that leads outside. Although the fence is well constructed and designed to prevent injury from impaling, both sides are surrounded by concrete.</p>	<p>The perimeter fence outside Kauri wing secure unit poses a risk to residents. The fence needs to be heightened.</p>	<p>Increase the height of the perimeter fence outside Kauri wing in ways that deter anyone from attempting to climb it.</p> <p>60 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Low</p>	<p>Cleaning methods and systems are safe, hygienic and effective. There are sufficient hours allocated seven days a week for the provision of cleaning and laundry services.</p>	<p>Residents, relatives and staff were not satisfied with the results of the current laundry</p>	<p>Take action to improve the effectiveness and standard of laundry</p>

		Families interviewed described loss and damage of residents' clothing, residents were dissatisfied by the time it took for personal clothing to be returned and there were reports of bed linen shortages.	services.	services. 90 days
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	<p>During an interview with the infection control co-ordinator (ICC) and the FM a document was presented outlining the role of an infection control team, in implementing and reviewing the infection control programme. Interviews with the FM and ICC, however identified there is no infection control team operating at Kimihia. As a result, the ICC was not aware that the responsibility to review the programme was part of the role. A review of the programme is needed to clarify who is responsible for managing the IC programme. Interviews, documentation and observations verified the safety of residents, staff and visitors has been maintained, despite the review not being undertaken</p>	<p>The infection control programme at Kimihia has not been reviewed since 2019 and is not fully reflective of the processes operating at Kimihia at this time.</p>	<p>Provide evidence the infection control programme is reviewed annually.</p> <p>180 days</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of</p>	PA Low	<p>Restraint assessment, consent, monitoring and individual review was occurring in ways that meet these standards. The restraint register is kept updated and restraint activity is discussed monthly at meetings but a quality review that determines trends and considers all elements a) to h) has not occurred.</p>	<p>There has not been a formal quality review of restraint practice for more than 18 months.</p>	<p>Provide evidence that a comprehensive quality review of all restraint practices occurs regularly.</p>

<p>consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>				180 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.