

Kamo Home & Village Charitable Trust - Kamo Home and Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Kamo Home & Village Charitable Trust	
Premises audited:	Kamo Home and Village	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 10 February 2022	End date: 10 February 2022
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:	71	

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 Hospital provides rest home, hospital and secure dementia care services for up to 73 residents. The service is operated by the Kamo Home and Village Charitable Trust and is managed by a general manager and group care manager. Residents and families interviewed spoke positively about the care provided.

The unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the Northland District Health Board (NDHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, staff and a general practitioner.

There were no new areas identified as requiring improvement and there were no areas to follow-up from the previous audit.


Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open disclosure between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreter services or translation services if required.

A complaint register is maintained with complaints 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.
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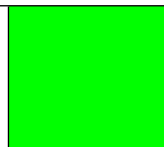
The business and quality and risk management plans include the scope, direction, mission statement and values of the organisation. Monitoring of the services provided and reporting to the Kamo Home and Village Charitable Trust is regular and effective. The facility is managed by the general manager who is responsible for three aged care services owned and operated by the trust. The general manager is supported by the group care manager and onsite clinical nurse managers, one of whom is the general practitioner link nurse. Additional management staff have roles such as for property and maintenance, education, and human resource management.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends, and leads to continuous quality improvements. Staff are involved and feedback is provided from residents and families. Adverse events are documented with corrective action plans implemented. Actual and potential risks, including infection prevention and control and health and safety, are identified and mitigated. Policies and procedures support service provision and were current and reviewed on a regular basis.

The appointment, orientation/induction and management of staff are based on good human resource practices. Education provided supports safe service delivery. Performance appraisals are performed for all staff annually. Staffing levels and skill mix meet the changing needs of residents.

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.

The registered nurses (RNs) and general practitioner (GP) assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular basis. Residents are referred or transferred to other health services as required.

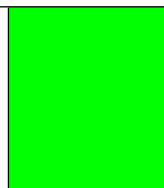
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents, with special needs catered for. Food is safely managed. Residents confirmed satisfaction with the meals.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The building warrant of fitness is current and displayed at reception.

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.

There are clear and detailed documented guidelines on the use of restraints and enablers and for managing challenging behaviours. There were five residents using an enabler voluntarily on the days of the audit. There were no restraints being used. Staff interviewed demonstrated a good understanding of enabler use and receive ongoing training on restraint minimisation and safe practice.

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 surveillance undertaken is appropriate for the size of the facility. Infection results are 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	16	0	0	0	0	0
Criteria	0	39	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/compliments policy reviewed meets the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families when the resident is admitted to this service and those interviewed were well informed. Compliments are acknowledged and fed back to staff.</p> <p>The complaints register is maintained electronically and was reviewed. There have been 27 verbal and written complaints in the last 12 months and actions were taken through to an agree resolution and completed within the required timeframes. Complaints followed through were effectively closed out and dated. Improvements were made where possible for quality improvement.</p> <p>The general manager (GM) is responsible for complaints management and follow-up. All staff interviewed confirmed a sound knowledge and understanding of the complaint process and what actions where required. Complaints are reported by the GM and discussed at the board meetings held monthly. No external complaints have been received.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents, relatives/representatives with enduring power of attorney (EPOA) stated they were kept well informed about any changes to their own or their relative's health status and were advised in a timely manner about any incidents that may have occurred or any urgent medical reviews. This was well supported in residents' individual records reviewed. There was evidence of resident/family/EPOA input into the care planning process and regular multidisciplinary reviews. Senior staff interviewed understood the principles of open disclosure. The policy sighted</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>meets the requirements of the Code.</p> <p>Interpreter services can be accessed through the Northland District Health Board (NDHB) if required and through the community at large. Several staff members were able to support residents where English was their second language and interpreter services were rarely needed.</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 governance organisational structure was reviewed. The organisation has three aged care facilities and all report to the general manager and the board which is a charitable trust. The trust board comprises of six trustees and a chairperson has been appointed. The GM has been in this position for 11 years and is present at each monthly board meeting. A report on the three facilities is presented to the trust board. Reports reviewed covered occupancy, safe staffing indicators, human resource issues, performance balanced score card (system adopted by the organisation), any risks or Section 31 notices, if applicable, and incident data from all sites, infection control (update on COVID-19), and health and safety. Continuity of care/growth, finances and health and safety are considered and discussed at length.</p> <p>The mission statement and values are clearly displayed at Kamo Home and Hospital at reception and documented in the service information provided to residents/families on admission. The organisation's business plan is documented 2020 – 2022. The vision, mission, purpose, priorities, key initiatives, expectations and values are reviewed at the end of each year. COVID-19 has impacted on some of the strategies in place. The plan is comprehensive but comprehended by staff. Staff have access to the plan as needed. The board accepts and adopts the business plan after each review.</p> <p>The service is managed by the GM who holds relevant nursing and business qualifications. Responsibilities and accountabilities are clearly defined in a job description and individual employment agreement. The GM is supported by the group care manager (GCM), support services manager (SSM) and a finance manager (FM). In addition to the management team there are two human resource managers who share this role, and one is also the educator for the organisation. The group care manager ensures the day- to-day clinical management and health and safety requirements are met at Kamo Home and Hospital and reports to the GM regularly. The organisation's chaplain is readily available across all services. The GCM interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending relevant courses and events related to aged care and other topics of interest.</p> <p>The service holds contracts with the NDHB for hospital (medical and geriatric), rest home, respite care and secure dementia care. There are also 15 occupational right agreement (ORA) studios. Residents in two studios were receiving care input as needed. On the first day of audit there were seventy-one (71) residents. This included 39 hospital residents, eight (8) rest home, twenty-three (23) secure dementia care residents and one respite care resident who was receiving services in the dementia care service.</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>The organisation has a planned quality and risk system that reflects the principles of quality improvement. The quality and risk plan was developed and implemented in November 2020 with the next review due in November 2022. This includes management of incidents and accidents, complaints, internal audit activities, regular satisfaction surveys, monitoring of outcomes, clinical incidents including infections, restraint minimisation and safe practice. All information is directly informed/generated through the electronic system in place for the organisation. All quality checks including the admission process, restraint, incident/accidents are logged/fed into the matrix system which is scored and automatically places the outcomes/deficits into an alert system of green, amber and/or red. Graphs can be generated for visual acknowledgement as required. The quality improvement plan records any deficit or issue as an area for quality improvement/initiative. The responsibility for the raised quality initiative is assigned to a key person to work through and when actioned the quality improvement is signed off. The GM explained the current quality performance system (QPS) which works very well for this organisation. Benchmarking occurs with other like organisations nationally and internationally with Australia.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and risk management monthly meetings. Staff reported their involvement in quality and risk management through audit activities. The programme has been set for the year for all meetings, along with the staff education plan.</p> <p>Annual resident/family surveys are completed annually. The October 2021 survey was reviewed with positive feedback provided. The staff survey completed separately provided good feedback and staff were positive about their workplace. The results were reported to the board. Any areas for improvement are acknowledged and included in the quality improvement plan for the service.</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 GM is responsible for the document control system, ensuring a systematic and regular review process occurs and includes referencing of relevant sources, approval by the board, if necessary, distribution and removal of obsolete documents. The archived records are stored electronically and can be retrieved when needed.</p> <p>The GM, group care manager and the management team are familiar with the Health and Safety at Work Act (2015) and ensure the implementation requirements are effectively managed. Training is provided to all staff during orientation/induction and annually on the quality and risk management system requirements. The service has an up-to-date hazard and risk register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse,</p>	<p>FA</p>	<p>Policies and procedures are accessible to guide staff on all aspects of incident/accident and adverse event reporting. A sample of incidents were reviewed and showed that all details were completed as required. Incidents were investigated, action plans developed and actions followed-up in a timely manner. All residents' incidents are logged into the electronic system and the resident's individual record is maintained and kept up to date also</p>

<p>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>electronically. Staff incident/accidents are logged onto the system in place under health and safety. The clinical charge nurse and the registered nurses are responsible for maintaining the data base.</p> <p>On a monthly basis, the incident/accident data base is used for the clinical report to the GM. This includes data on falls, skin tears, infections, medication errors and challenging behaviour incidents. The group care manager oversees all sites in relation to clinical incidents. There have been four Section 31 notifiable incidents recorded since the last audit to HealthCERT, one related to staffing and three related to pressure injuries. All were dealt with appropriately. The Section 31 notice regarding the registered nurse (RN) shortage and RN cover for the facility, was originally sent to HealthCERT by the GM. This was then referred to the NDHB from HealthCERT and a full review was undertaken on the RN staffing status at the time. The staffing issue was closed out effectively by the NDHB as an additional RN was employed.</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 resource management policies and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed confirmed that the organisation's policies and procedures were being consistently implemented and records were well maintained by the two human resource managers. One of the two HRMs is responsible for the care and nursing staff and the other the domestic staff. Both are supported by the clinical charge nurse, the GP nurse and the GCM. The recruitment process includes referee checks, police checking and validation of qualifications and practising certificates (APCs) for all health professionals where required. This information is stored electronically. Staff records contained all information required, including the application, acceptance documentation, curriculum vitae (CV) education/competency records, job descriptions, the individual employment agreement and appraisal forms. Staff checklist are maintained and completed on the front of each staff record folder reviewed.</p> <p>Staff orientation/induction records included all necessary components relevant to each role. This is signed off in three months, after staff commence their area of work. Staff interviewed reported that the orientation prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance appraisal three monthly and annually. The SSM is responsible for the maintenance team and completes the required orientation check list and maintains the training they each attend. Records reviewed demonstrated all staff had completed the required training and annual appraisals were verified.</p> <p>Continuing education is planned annually and includes all mandatory training requirements. The education/human resource manager interviewed maintains all staff education and is the education assessor for this service. The training plan for 2022 was sighted. The care staff (83) have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the service provider's agreement with the NDHB. All care staff who work in the secure dementia care service have completed the relevant dementia training. All training for staff was verified. All registered nurses and the members of the maintenance team have completed first aid training, and this was validated. Seven of twelve registered nurses have completed the interRAI training and have completed the required annual competency training as required.</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 rationale covering all service provision provided at Kamo Home and Hospital for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week. The clinical charge nurse and registered nurses adjust staffing levels to meet the changing needs of residents. An after-hours on call roster is provided. Staff reported that good access to advice is readily available when needed.</p> <p>Residents and family reported there were adequate staff available to complete the work allocated to them. Observation of a six week roster cycle confirmed adequate staff cover has been provided with staff replaced in any planned or unplanned absence. All registered nurses and the maintenance team are first aid certified. There is twenty four hour/seven days a week registered nurse cover.</p> <p>One experienced registered nurse covers the dementia care service Monday to Friday. This person supports continuity of care and service delivery and is able to provide advice to staff and families. An activities coordinator working in the secure dementia service is currently training to be a diversional therapist. This coordinator works 30 hours a week in this area of service delivery. Activities are available twenty four hours a day if needed. In addition to this position, there is a diversional therapist and an activities coordinator who cover the rest home and hospital services with a varied activities programme which was reviewed.</p> <p>Five staff cover the cleaning and laundry seven days a week. No bureau staff are employed. For care staff the GM reported that the service is currently covered well above the required safe staffing levels required. Two casual care staff are available if needed. Property management is managed by the SSM. Staff are contracted, such as the hairdresser, podiatrist and physiotherapist. There is sufficient staff to cover the ORA studios as deemed necessary.ome and Hospital for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week. The Home a Residents in two studios are currently receiving planned cares and assistance as needed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and meets the legislative requirements.</p> <p>Kamo Home and Village uses an electronic medicine management system. The electronic system is accessed using individual passwords. The clinical charge nurse was observed administering medication correctly. They demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines had current medication administration competencies.</p> <p>The electronic prescribing practices included the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The three-monthly medication reviews were consistently recorded on the electronic medicine charts sighted. The electronic medicine charts sampled for review had current photos and allergies were documented.</p>

<p>guidelines.</p>		<p>The service uses pre-packaged medication packs which are checked by the RNs on delivery. The medication was stored safely, and medication reconciliation is conducted by RNs when a resident is transferred back to the service. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. There were no vaccines kept on site.</p> <p>There were no residents who were self-administering medicines on the day of the audit. Appropriate processes were in place to ensure this was managed in a safe manner when required. Regular monitoring of the medication management system was completed through internal medication management audits.</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>The food service is provided on site by a contracted external provider and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a six weekly cycle and was reviewed by a qualified dietitian in November 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with a current food safety plan and registration issued by the Ministry of Primary Industries. The food control plan expires in January 2023. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The chefs and the kitchen hands have completed relevant safety training.</p> <p>Nutritional assessments were completed for each resident on admission to the service 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. Nutritional supplements were provided for residents with loss of weight issues. Residents in the secure dementia unit always have access to food and fluids to meet their nutritional needs. Special equipment, to meet resident's nutritional needs, was available.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family/whanau in interviews and satisfaction surveys. The food was served in the respective dining rooms. Residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Residents stated that food options/alternatives were provided when requested.</p>
<p>Standard 1.3.6:</p>	<p>FA</p>	<p>The interventions documented in the long-term care plans reviewed were adequate and appropriate to address</p>

<p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>residents' assessed needs and desired outcomes. Observations and interviews with residents and family/whānau verified that care provided to residents was consistent with their needs, goals, and the plan of care. A diverse range of residents' individual needs was met as confirmed in interviews and verified in sampled care plans. The GP confirmed that medical input was sought in a timely manner, and care was provided as prescribed. Adequate equipment and resources were available to meet the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is overseen by a diversional therapist (DT) who is supported by two activities coordinators (ACs). The chaplain and two volunteers also help with the activities. The DT and ACs completes the activities assessments for all residents with input from residents and family/whānau or the EPOA. An activities profile is completed on admission to ascertain residents' needs, interests, abilities, and social requirements. A monthly activities programme is completed and was posted on the notice boards around the facility.</p> <p>The planned activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents can participate in individual or group activities as desired. Residents were observed participating in various activities on the day of the audit. The activities on the programme included celebration of monthly themes, birthday celebrations, external entertainment, van outings, church services, bowls, quizzes, puzzles, exercises, massage, manicure and monthly residents' meetings. There is a library service through the library bus that visits the service and residents can borrow books as desired, plus an onsite library that the residents utilise as well.</p> <p>Residents' participation in activities were recorded daily and notes written with daily logs. The activity needs were evaluated as part of the formal six monthly interRAI and care plan review. The satisfaction survey and residents' meeting minutes verified residents' and family/whānau involvement in evaluating and improving the activities programme. Residents and family/whānau interviewed confirmed satisfaction with the programme.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living with dementia. The residents had free access to the secure garden. Activities are offered at times when residents are most physically active and/or restless. This included short walks in the secure garden, van outings, colouring, and arts and crafts. The residents in the secure unit can join the activities group for the hospital level and rest home level residents with an escort. The DT reported that the activities are flexible and can be changed to meet the needs of the residents.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes by the caregivers. If any change is noted, it is reported to the RNs. The RNs review and document in the progress notes at least weekly and more</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>frequently when indicated as determined by the resident's condition.</p> <p>The reviewed records showed that formal long-term care plan evaluations occur every six months following the six-monthly interRAI reassessments. The behaviour management plans for residents in the dementia unit were evaluated regularly. The evaluations indicated the degree of achievement or response to the interventions and/or support provided, and progress towards meeting the desired outcome.</p> <p>Short-term care plans and behaviour monitoring charts were consistently reviewed, and progress evaluated as clinically indicated. Short term care plans sighted were for urinary tract and wound infections. Residents and family/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (BWF) expiry 01 June 2022 is publicly displayed. All buildings, plant and equipment comply with legislative requirements.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, oral, multi-resistant organisms, gastrointestinal, eye, and the upper and lower respiratory tract. Infections are recorded on the infection form electronically. The infection control coordinator reviews all reported infections regularly. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and this is reported to the management team and reported to the Trust board members monthly. Recommendations to assist in infection reduction and prevention were acted upon. Infection control measures recommended by the ministry of health for the management of the COVID-19 pandemic were implemented. There was no reported infection outbreak reported since the previous audit.</p>
<p>Standard 2.1.1:</p>	<p>FA</p>	<p>The nominated restraint coordinator is the GM who is capably carrying out the tasks allocated in the job description.</p>

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>The restraint register/report clearly showed five residents voluntarily using bedrails as enablers for safety at the time of audit. No restraints were in use. No restraints have been used for over twelve months. The service provides a restraint free environment. All staff are expected to attend ongoing education on restraint minimisation and safe practice and be assessed as competent annually. At the time of this audit, staff competency with restraint was 100%.</p>
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Specific results for criterion where corrective actions are required

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

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

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

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, 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.