Kamo Home and Hospital Limited - Parahaki Court

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Kamo Home & Village Charitable Trust
Premises audited:	Parahaki Court
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 May 2018 End date: 10 May 2018

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: 24

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

Parahaki Court is one of three aged related residential care services operated by Kamo Home and Village Charitable Trust and provides care for up to 25 residents requiring rest home level care. At the time of this certification audit 24 beds were occupied.

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

All residents and family members interviewed were very satisfied with staff, and the services provided.

There are two areas identified for improvement related to staff training, and aspects related to the use of enablers.

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.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service links with a range of specialist health care providers to support best practice and meet resident's needs.

Complaint forms are available to residents and family. There have been no complaints since the last audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

The organisation's philosophy, mission and strategic intent statement are identified in the business, quality and risk plan. Significant changes have occurred since the last audit in developing and implementing a new management structure and associated systems and processes to operate all three aged care facilities owned by Kamo Home and Village Charitable Trust, including Parahaki Court into one organisation. The group general manager, and the other three members of the management team work together, with the Parahaki Court clinical charge nurse, to ensure the services offered meet residents' needs, legislation and good practice standards.

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

New staff have an orientation. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met. The service has a documented rationale for staffing which is implemented.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, 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 and timely 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 verified satisfaction with 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 service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There are documented emergency management response processes which are understood and implemented by staff. This includes six monthly fire drills. The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no significant changes to the facility since the previous audit, with the exception of security cameras being installed.

The facilities meet residents' needs and provide furnishings and equipment that are regularly maintained and updated. Bedroom areas allow residents to move around with or without assistance. There are adequate toilet, bathing and hand washing facilities.

The open plan lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility is kept at a suitable temperature. Opening doors and windows creates an air flow for ventilation. The outdoor areas provide furnishings and shade for residents' use.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

Policies and procedures are available for staff on the use of enablers and restraint minimisation practices. The policy and procedures are currently under review. There were no restraints in use during audit. Four residents have enablers in use. Staff are provided with orientation and ongoing education on restraint minimisation and use of enablers.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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, 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	43	0	2	0	0	0
Criteria	0	91	0	2	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The organisation has developed policies, procedures and processes 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.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form; however not all not all residents using an enabler have a consent form (see criterion 2.1.1.4). Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available 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.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. There is a main lounge and adjourning dining area and outside sitting areas where family and residents can meet. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Parahaki Court implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family and staff reported their understanding of the complaints process and noted they had no complaints. Complaints / compliment forms are present at the main entrance and include an area for the recording of complaints, feedback and compliments. A complaints register is maintained. There have been no complaints received from residents or family members, the Ministry of Health or Health and Disability Commissioner since the last audit. An investigation by the DHB into a resident with a pressure injury occurred in September 2017 (refer to 1.2.4).
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents 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 discussions with staff. The Code is displayed in the reception area together with information on advocacy services, how to make a complaint and feedback forms. Orientation of a new resident and their family is a role that the lifestyle activities co-ordinator preforms and includes the orientation of the facility, introduction of key staff and a contact for families needing extra support. Evidence of this occurring was sighted as being signed and completed on the long-term care plans.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by continuing to attend community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. There are currently six residents whom have chosen to keep their own GP and several residents are supported to maintain their independence by continuing to attend activities and groups in the community and complete their own shopping. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. 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. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Staff support residents in the service 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. The clinical charge nurse (CCN) interviewed reported that there is one resident who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced and integrated into long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Whanau were not available for interview, however the Māori resident interviewed reported that staff acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in initial, long term care plans and interRAI assessments reviewed.

which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. The CCN/RN has records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. A general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included the knocking on resident's doors before entering, day to day conversations observed between staff, residents and their families.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English at the time of audit, staff able to provide interpretation as and when needed, and the use of family members.
Standard 1.2.1: Governance	FA	Parahaki Court is one of three aged related care facilities owned and operated by Kamo Home and Village Charitable Trust (KHVCT). Significant governance changes have occurred since the purchase of Parahaki Court,

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		with KHVCT developing and implementing a new governance / management structure. New roles have been developed titled group care manager, group business manager, and group support services manager. The personnel in these roles are responsible for developing and / or reviewing processes and systems to ensure they are current and fit for purpose across all three aged related residential care facilities. Specific roles and responsibilities are detailed in position descriptions and the reporting lines are also detailed in the organisation chart. Activities including (but not limited to) maintenance / facility management, human resources, staff training, quality and risk activities, clinical care, and laundry services are overseen centrally. These roles report to the group general manager, who is responsible to the Board of Trustees. The clinical charge nurse (CCN) role is responsible for ensuring the services provided meets the needs of residents at Parahaki Court on a day to day basis. Kamo Home and Village Charitable Trust has a documented mission statement, philosophy and values that is focused around faith, and the provision of individualised, quality care. The group manager advised that some aspects are currently under review. The Board of Trustees, comprising seven members meets monthly. The meeting is also attended by the group general manager. The chairperson reports having regular meetings or other communications with the group general manager as applicable / required and is satisfied communication is timely and appropriate. Minutes of BOT meetings sighted included discussion on quality and risk, health and safety, future planning, human resources, business opportunities, and the continuum of care. A proposal for the restructure was developed that was subsequently reviewed and approved by the BOT. A more detailed plan related to the implementation was developed including timeframes, and who was responsible for the activities. The clinical charge nurse is an experienced aged care registered nurse with a current annual practising certificate. The CCN previously worked at Parahaki Court Rest Home as the nurse / facility manager for 14 years. The CCN is readily available to residents and family as verified by residents and families interviewed. The management team including the CCN monitors the progress in achieving business goals, and resident care needs via day to day care / activities, resident / family feedback and monitoring of the results of quality and risk activities. The CCM participates in relevant ongoing education as required to meet the provider's contract with Northland District Health Board (NDHB) and has a current interRAI competency. The service has a contract with NDHB for the provision of aged related rest home level care. All except one resident are reported to have been assessed as requiring rest home level care. One resident entered the facility seven weeks prior to audit for respite care (privately funded). Discussions have occurred with the resident / next of kin about the need for the resident to be referred to the NDHB needs assessment service for review of the resident's ongoing care needs.

Standard 1.2.2: Service Management 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.	FA	The group general manager is responsible for services in the clinical charge nurse's absence. The group general manager is a registered nurse with a current annual practising certificate (APC). The group general manager is appropriately experienced, and previously the manager for one of the three aged care facilities owned by KHVCT. The group general manager advises, she is responsible for the management of the service with the assistance of registered nurses that work at other KHVCT facilities to provide the clinical care.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Parahaki Court has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, benchmarking, health and safety reporting, hazard management, infection control data collection and management, and complaints / compliments management. Restraints are not in use. Regular internal audits are conducted, which cover relevant aspects of service including aspects of care, documentation and medicine management. The quality and risk programme / benchmarking programme previously used by Kamo Home and Village facility has been implemented at Parahaki Court. The results are benchmarked with other providers (both nationally and in Australia). In addition, the number of falls and pressure injuries are benchmarked with other aged residential care facilities within Northland DHB. Quarterly reports are received from both benchmarking organisations that detail Parahaki Court's position for the included indicators. Benchmarking reports summarise where Parahaki Court features amongst the participating organisations, and the national / international reports clearly details any variation since the last audit (positive, negative or neutral). Parahaki Court is well placed in the Australia / New Zealand data in relation to medicine errors, the results of the medicines and quality of care audits, and for resident falls with injury. Progress is monitored by the CCN and the group business service manager who provides oversight of the quality and risk programme. A resident and family satisfaction survey has recently commenced. This is the first formal survey completed since the facility's change of ownership. No responses have been received as yet. Staff, resident and family interviewed expressed a high level of satisfaction about the services provided at Parahaki Court. If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions were developed and implemented. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The minutes of staff meetings are made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations / policies. Quality and risk activities and outcomes are also discussed at the monthly management meeting that is attended by the group general manager, the group care manager, the

		group business services manager and the group support services manager. Other meetings are held by the group care manager with the clinical charge nurses of all three KHVCT facilities. Meetings are held three monthly with residents to obtain resident feedback on services, food, and activities as well as obtain information for future planning. The minutes of the recent meetings were sighted by the auditor reviewing service delivery. Policies and procedures were readily available for staff. Policies, and procedures in use are now those used KHVCT wide. Policies are reviewed at least every two years or sooner where required and are approved by the group general manager. Procedures are reviewed in response to changes in policy, or where necessary in response to incidents / accidents, or where processes / systems are identified as needing improvement. Process maps are maintained electronically. The current version of associated procedures and template forms are embedded in the process map to ensure the most current version of documents is available and used at the time. One paper copy of documents is available for staff. The group business services manager is responsible for document control processes. Policies and procedure are discussed during the staff education programme. Staff, resident and family interviewed expressed a high level of satisfaction about the services provided at Parahaki Court. Actual and potential hazards and risks are identified in the risk and hazard register. These contains potential and actual hazards and risks common for all three facilities, as well as individual facility specific hazards and risks. Mitigation strategies have been documented. Staff confirmed that they understood and implemented documented hazard identification processes. Maintenance issues are reported in real time and the records sighted verified reported events have been promptly addressed. The group support services manager advises all requests must be responded to within three working days.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme. Applicable events are being reported in a timely manner and disclosed with the resident and/or designated next of kin. This was verified by residents and all family members interviewed. A review of reported events including falls, skin tears, and a pressure injury demonstrated that incident reports are completed, investigated and responded to in a timely manner. Staff communicated incidents and events to oncoming staff via the shift handover. Events have been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted. Incidents (eg, falls and wounds) are included / summarised during the interRAI reviews for individual residents. The incident register is able to be searched by resident, date, and type of event, as well as other components where required. The service is benchmarking falls and pressure injury rates per 1000 occupied bed days with other aged

		residential care facilities in NDHB region. There has been a reduction is falls since August / September 2017. One resident with a grade two pressure injury in February 2018, has been included into the Kamo Home and Village data as the resident was transferred to a higher level of care. There has been a total of two residents with pressure injuries at Parahaki Court since the change in rest home ownership. The group general manager advised a total of two essential notifications have been made by KHVCT in relation to Parahaki Court since the last audit. This included a resident with a pressure injury. A review by the DHB occurred in September 2017 in relation to pressure injury prevention and management processes. Air mattresses are now in use for residents at increased risk. Staff have been provided with comprehensive education on pressure injury prevention, wound care plans are documented, and wounds monitored. The group general manager is able to detail the other type of events that require reporting.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Copies of the annual practising certificates (APCs) were sighted for the three general practitioners (GPs), the five pharmacists, the podiatrist, the physiotherapist, the group general manager, and the clinical charge nurse. Recruitment processes includes completing an application form, conducting interviews and reference checks. Recruitment and training records of staff employed by the previous owner are maintained in a historic file. New personal files have been created that include the job description, confidentiality agreement, health and safety induction record and annual practising certificate (where applicable). The job description / employment contract and confidentiality documents include a statement advising staff of privacy / confidentiality requirements. Annual performance appraisals have been undertaken with staff who have been employed by KHVCT for 12 months or longer. Mentoring / coaching meetings also occur in-between times. New employees are required to complete a health and safety induction and an orientation programme relevant to their role. A workbook / checklist is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. A staff education programme is in place with in-service education identified and provided monthly. An annual competency assessment process is also in place for caregivers and support staff. The competency assessment and associated documentation has not been completed for the support staff. Records are not available to demonstrate one of the two cooks has completed food safety training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and	FA	A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider's contract with Northland District Health Board (NDHB) and safe staffing indicators. Required staffing numbers and actual staffing numbers are monitored monthly and summarised in reports to the board. The current roster was reviewed. Where there are changes in hours worked different to that noted on the roster;

safe service from suitably qualified/skilled and/or experienced service providers.		these changes are recorded on the rosters. The rosters sighted demonstrated that there is a clinical charge nurse (CCN) is on duty Monday to Friday days, for 40 hours a week. The CCN is no longer responsible for most of the human resource activities, overseeing maintenance, housekeeping and food services, or facilitating education as these and other activities are now overseen by the four members of the KMVCT group management team. This enables the CCN to be focused on resident clinical care. At least one day a week an additional caregiver is rostered on the morning shift to enable the CCN to undertake activities including interRAI assessments. An additional caregiver has been rostered on duty during the audit to free up the CCN to participate in the audit. The group care manager has 10 hours per week of time allocated to Parahaki Court to support the CCN with clinical care and activities. Some of this time is spent on site, and other activities undertaken that are office based (eg, planning for the change to an electronic medicine management system). The group care manager is expected to be on site at least once a week, although this has not occurred for a variety of reasons in the three weeks prior to audit. There are normally two caregivers rostered to work on the morning and afternoon shift with one staff member finishing at 1.30 pm and the other staff member working till the shift change. There are two caregivers rostered on the afternoon shift with one rostered to work from 4 pm till 9 pm and one for the entire shift. There is one caregiver on duty from 9 pm to 6.45 am. A senior caregiver is on duty at all times. The senior caregivers and the CCN have a current medicine competency and first aid certificate. The caregivers interviewed advise if advice or support is required afterhours, they phone the RN on duty at Kamo Home and Village. There are currently no staff working towards completing an industry approved qualification. However, records sighted identify four staff have an industry approved qualification or equivalency based on experience at level three, four staff at level four, and two staff have a level two qualification. All laundry services are provided by staff in the centralised laundry at Kamo Home and Village facility. A housekeeper is rostered on duty 9 am to 1 pm, seven days a week. A cook is rostered on duty from 7 am to 3.30 pm, seven days a week. Two staff share this responsibility. The main meal is provided at lunchtime. Four staff based at Kamo Home and Village share responsibilities for facility management, maintenance, gardening and repairs. Activities are provided weekdays by one of the four activities staff based at Kamo Home and Village, normally from 9 am to 3pm. One day a fortnight a senior caregiver at Parahaki Court facilitates the programme from 9 am to 2pm. Caregivers and housekeeping staff interviewed verified staffing is usually as detailed above. Residents and the family member interviewed confirmed their personal and other care needs are being well met. Staff spoke positively about how they assist new residents with diminished mobility and encourage their participation in day to day activities. As a result, significant improvements in at least one resident's mobility was reported to have occurred.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. The group business services manager interviewed reported that the most recent archived records are held securely on site, older archived files are also stored at Kamo home and Village and then transferred to and stored at a professional secure location of site (not observed at time of audit) and are readily retrievable using a sighted cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	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 are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. 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 details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. The CCN interviewed reported that there is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes.
Standard 1.3.12: Medicine Management	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		A safe system for medicine management (using a paper-based system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used. There were no residents who were self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by one of two cooks, afternoon kitchen assistant, and supporting care staff, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Whangarei city council expires on the 31 January 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Kitchen assistants and care staff have completed relevant food handling training, however records were not available to demonstrate one of the two cooks has completed industry approved training on food safety (see criterion 1.2.7.5). 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. The kitchen currently supports six residents requiring a modified textured diet and one resident who is vegan.

Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	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. There were no recent examples of this occurring. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information; however, not all residents who are supported by an enabler have this information documented in their interRAI assessment (see criterion 2.1.1.4). Twenty three of 24 residents have a current interRAI assessment completed by the CCN/RN trained interRAI assessor on site. One resident entered the facility seven weeks prior to audit for respite care (privately funded) having required surgery following a fall at home. There was evidence of an initial assessment, short and long-term care plans. Discussions had occurred with the resident and their family and a needs assessment referral had been requested at the time of audit. The CCN is also having discussions with family due to one resident admitted in 2014 now requiring a higher level of care due to significant reduced mobility. The CCN interviewed reported that there are no residents at the time of audit with pressure injuries. The wound management log identified two residents supported with skin tears and one resident requiring a protective dressing due to exploration surgery in an acute setting. All three residents are having regular dressings as sighted by individual wound management plans, and supportive equipment (eg, air mattresses), and have been seen by the GP. If a resident is identified with a pressure injury the CCN interviewed reported that this information is entered into the pressure injury register. An incident form is completed, and a wound care management plan is developed in association with assessments to assess skin integrity. The GP is involved and if a wound is not healing a referral is sent to the district nurse for wound specialist advice. A pressure injury management chart is also commenced which identifies date and time of equipment checks, such as the air mattress, skin checks and repositioning of the resident. Residents and families confirmed their involvement in the assessment process.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed; however, not all residents with an enabler had this identified in their care plan (please see criterion 2.1.1.4). Care plans evidence service integration with separate care staff and CCN progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of 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, communication and care provided is excellent. 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.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is overseen by the resident lifestyle co-ordinator (who oversees the three facilities) and five activities staff whom are rostered to support the residents Monday to Friday from 9.30 am – 3.30 pm. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents individually and as a group. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive and enjoy living close to town, being able to maintain their independence and/or be supported with their day to day activities of living. This includes the four van outings a month, supporting all residents with different mobility needs to remain connected with the community.
Standard 1.3.8:	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported

Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', there are six residents who choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or CCN/RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist and mental health services for older persons. The resident and the family/whānau 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 circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies detail how waste is to be segregated and disposed. The policy content aligns with current accepted practice. Chemicals sighted were stored in designated and secure areas. Material safety data sheets detailing actions to take in the event of exposure were sighted for chemicals in use. Applicable staff have been provided with training on chemical safety and handling. Appropriate personal protective equipment (PPE) was available on site including disposable gloves, long sleeve plastic gowns, masks, and face protection. An emergency kit with PPE is also available for use in an outbreak or other significant event. Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system. Staff confirmed receiving education on handling chemicals and waste as part of health and safety induction and orientation.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a current building warrant of fitness (BWOF) with an expiry 1 September 2018. Ongoing checks to maintain the BWOF are occurring. Another company undertakes performance monitoring of clinical equipment and provides a written summary. Electrical equipment sighted had evidence of current electrical testing and tag checks. Electrical testing of new resident's personal electrical equipment is undertaken shortly after admission, and annually thereafter. Clinical equipment checked at random had a current performance validation, with the exception of one air mattress which is just overdue testing. Maintenance requests are identified and documented by staff when issues are noted. Requested tasks have been signed off as completed. The facility vehicle has a current registration and warrant of fitness. There is a covered front entrance area that residents and family can use, as well as furniture out the back of the rest home. These are appropriately furnished and include shade. Residents were observed to be mobilising independently including with the use of a mobility device in their bedrooms and throughout the rest home communal areas and outside areas. Monthly internal audits detail that the temperature of hot water is below 45 degrees Celsius in the areas tested, which rotates each month. The hot water temperature of rooms is sampled to ensure at least one room from each of the four gas hot water califonts is sampled each time. The results of the monthly tests were sighted.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Hand basins are present in each resident's bedroom or ensuite. Ensuite toilets are present in 18 of the residents' bedrooms. Waterless hand gel is also available for staff and residents at locations around the facility. There are four showers for resident use. There are separate bathroom facilities for staff to use. Privacy locks and signs are present on communal bathroom facilities.
Standard 1.4.4: Personal Space/Bed Areas	FA	All residents' bedrooms are single occupancy. The rooms all contain space for the residents, personal possessions and use of mobility devices, if required. Residents were sighted mobilising inside the rest home independently, including while using a mobility aid.

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	All residents have single occupancy rooms. There are a number of other areas that residents can use for activities or to meet with family and friends. This includes the open planned lounge and dining room, and outside areas. The residents and family members interviewed confirmed that there is sufficient space available for residents and support persons to use in addition to the residents' bedrooms.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Policies and activity lists detail how the cleaning and laundry services are to be provided. All laundry including resident's personal clothing is sent to Kamo Home and Village daily and washed and returned. Fragile items can be hung to dry at Parahaki Court or on clothes lines / racks at Kamo Home and Village. The residents and family members interviewed confirmed the rest home is kept very clean and tidy and residents' laundry is washed and returned in a timely manner. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with the service requirements. The resident satisfaction survey includes questions related to environmental cleanliness and laundry services. This is currently in progress. Chemicals are stored in designated secure cupboards which are locked. A house keeper interviewed confirmed being provided with training on the safe handling of chemicals and had written instructions readily available on the use of products and required cleaning processes / activities. Each resident's bedroom is 'spring cleaned' once a month. A register is kept of when each resident's room is due and staff indicate once completed. Instructions for managing emergency exposures to chemicals is readily available to staff.
Standard 1.4.7: Essential, Emergency,	FA	The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 17 March 2000. Fire evacuation drills are conducted six monthly, and fire safety procedures discussed with staff as a

And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.		component of the KHVCT health and safety induction for all staff. A wall mounted summary of the fire evacuation procedure is present in the facility. Policy documents provide guidance for staff on responding to civil emergency and disaster events. Review of the staff files and training records verified that staff are provided with first aid training, and at least one staff member with a current first aid certificate is rostered on duty each shift. There are sufficient supplies available of dry food, lighting, a radio and batteries, and other clinical supplies for use in emergency. A gas BBQ for cooking is available (Stored at Kamo Home and Village) along with spare blankets. Water bottles, and a small water tank is onsite that contained sufficient supplies for use in emergency. Supplies are checked and rotated as required. Call bells are present in the bathrooms and residents' bedrooms. They alert via an audible sound and notification of the room number/location through to a centralised panel. Three call bells tested at random were fully functioning. All call bells are tested as part of the three-monthly maintenance audits. Persons entering the building come to the main entrance. The doors are locked at designated times, although family advise they are given access if presenting after this time. No concerns were expressed by residents or the family member interviewed about security arrangements. Caregivers advise they are required to check each resident on shift handover and regularly during the shift. There are new security cameras in use monitoring communal areas, entrances / exits and outside the facility. The group support services manager advises images are filed for up to one month, with stored images being accessible to the senior management team. Images are noted to be checked following some incidents including resident falls.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms have a window. Heating is via centralised heating in the bedroom wings and heat pump in the communal areas. Residents and family members interviewed verified the facility is normally suitably warm and ventilated. A lap blanket or jersey is used where applicable to meet individual resident's needs. Smoking is only allowed in a designated outside area.
Standard 3.1: Infection	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to

control management 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.		residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the local hospital infection control team. The infection control programme and manual are reviewed annually. The group care manager (GCM)/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the Group General Manager (GGM), Manager Business Support (MBS) and tabled at the management, infection control, RN monthly and staff meetings. This management committee includes the GGM, MBS, GCM and CCNs. 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 responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for eight months. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Staff are also supported by an enrolled nurse who completes training throughout the three facility sites. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures 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	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2018 and included appropriate referencing. 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. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.

the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the suitably qualified IPC coordinator and CCN. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. 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.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the manager business support (MBS) to the Group Care Manager (GCM), Group General Manager (GGM), Clinical Charge Nurse (CCN) and staff. The facility has had a total of 40 infections involving 22 residents since October 2017. Three residents have been identified with 18 of those 40 infections due to co-morbidities. One resident has been transferred to hospital level care at their sister facility. The two remaining residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked externally within the group and QPS three monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation	PA Low	Policies and procedures are available on restraint minimisation and safe use and the use of enablers. These documents are under review, in order to provide clearer guidance for staff on the use of restraint and enablers.

Services demonstrate that the use of restraint is actively minimised.		The use of enablers is not included in the residents' InterRAI assessments or for one resident in their care plan.

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)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	A staff education programme is in place with in-service education provided monthly. The topics are scheduled to align with Parahaki Court’s contract with NDHB, residents’ care needs, and quality and risk data. Education is planned for the next month and approved by the management team prior. The same in-service education is scheduled to occur at each of the three KHVCT facilities and staff can attend training at any site. The education programme is overseen / facilitated by the KMVCT educator. Education topics provided since April 2017 and 2018 year to date includes (but is not limited to); fire safety, Alzheimer’s awareness, skin tear prevention, documentation, pressure injury prevention (three different sessions), falls prevention, concerns /compliments, new policies, manual handling, incontinence, privacy / confidentiality, catering services / maintenance, the Code of Rights and coaching and mentoring. Education is provided by the educators, clinical care managers, registered nurses, or external speakers. Staff can also attend relevant external education. Records of education are maintained and copies of some education certificates are present in the staff files reviewed. There are processes in place to ensure applicable staff have competency for medicines management. An annual competency assessment process is	Four out of four support staff have not completed the competency assessment requirements. Records are not available to demonstrate one of two cooks has completed industry approved training on food	Ensure all support staff complete required competencies. Ensure all staff involved in food service have records of industry approved food safety training. 180 days

		in place for caregivers and this has been completed in sampled files. The annual competency for support service staff (housekeeping and catering staff) has not been completed in all four applicable staff sampled files (the sample was expanded to review this aspect). The competency includes (but is not limited to) locating chemical spill kit, safe food handling, safety procedures, managing challenging behaviours, and emergency preparedness. There are three rating options (requires assistance, independent and can provide support / guide others in the performance). Records are not available to verify one of the two cooks has completed industry approved training in food safety.	safety.	
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	Policies and procedures are available on restraint minimisation and safe use and the use of enablers. The restraint minimisation policy and associated procedure was updated in April 2018 and is under review again in order to provide more clarity around expectations for staff. The restraint and enabler terminology is used interchangeably in some of the documents. There are no restraints currently in use at Parahaki Court. Policy notes enablers promote independence, safety and comfort of residents. Staff interviewed are aware the use of enablers must be voluntary. The restraint coordinator for KMVCT is the group care manager. The position role and responsibilities are detailed. Caregivers and the clinical charge nurse interviewed could describe the difference between enablers and restraints. Four residents have enablers in use (bed loops, and a bed pole). The use of enablers was noted in three of the four applicable residents' care plans (either long term care plan or short term care plan) sampled. Evidence that the use of enabler is voluntary is via the resident signing their care plan), or obtained separately from one of the resident's. A combined (three facility) enabler register is used by KHVCT. The use of enablers was not included in any of the interRAI assessments for the four applicable residents. Two residents with enablers in use advised they are to help them get out of bed and are present at their choice. Another resident was observed to be using the bed loop to help sit up independently. New care staff are provided with orientation on the use of restraint and enablers and this topic was discussed with staff at change of ownership of the rest home. The topic is included in the ongoing education programme for staff.	The restraint minimisation policy uses restraint and enabler terminology interchangeably in some parts of the policy. None of the four residents had the need for the use of enabler's identified in their current InterRAI assessment. One of four residents did not have the use of enablers included in their care plan.	Ensure the restraint and enabler policies provide clear guidance for staff. Ensure the use of enablers is included in the resident's assessments and care plans. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.