

Kumeu Village Aged Care Limited - Kumeu 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: | Kumeu Village Aged Care Limited |
| Premises audited: | Kumeu 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: 11 March 2021 End date: 12 March 2021 |
| 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: | 96 |

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

Kumeu Village Aged Care Limited - Kumeu Village provides hospital services medical and geriatric, rest home and secure dementia levels of care for up to 101 residents.

This surveillance 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 and procedures, a review of residents' and staff files, observations, and interviews with residents, family members, managers, one of the two owners/directors, staff, and the general practitioner. Feedback from residents and family / whānau members was positive about the care and services provided.

No areas for improvement were identified at the previous audit. At this audit there are five areas for improvement identified relating to recruitment records, staff training/appraisals, evaluating the effectiveness of pro re nata (PRN) medicines, aspects of interRAI assessments, care plan development, and obtaining a dietitian review of the menu.

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. |
|--|--|--|

Open communication between staff, residents and families is promoted. There is access to interpreting services if required and most documents are in a language that is spoken and understood by the residents and relatives. Staff provide residents and families with the information they need to make informed choices and give consent.

Complaints management is well documented. All processes are undertaken to meet the standard's requirements.

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 medium or high risk and/or unattained and of low risk. |
|---|--|--|

The organisation's philosophy, mission and goals statements are identified in the objectives and quality improvement plan 2021/2022. One of the two facility owners is the general manager. The general manager and the other four managers work together to ensure the needs of the residents are being met. There is a new operations manager and a temporary clinical manager. The permanent clinical manager has been redeployed for a period of time.

The quality and risk system and processes support effective, timely service delivery. Policies and procedures are developed by an external consultant and personalised to reflect the services at Kumeu Village. The quality management system includes an internal audit programme, compliments, complaints management, incident/accident reporting, satisfaction surveys, restraint minimisation, and infection control data collection. Quality and risk management activities and results are shared with the management team and staff. Corrective action planning is documented.

Applicable staff and contractors maintain current annual practising certificates. New staff have an orientation relevant to their role. Staff participate in regular ongoing education. The service has a documented rationale for staffing which is implemented.

Continuum of service delivery

| | | |
|--|--|--|
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
|--|--|--|

Policies and procedures provide guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The nursing team is responsible for assessment, development, and evaluation of care plans. Care plans are individualised and developed in consultation with residents and family/ whānau.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP) and these were current. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Nutritional snacks are available for residents 24 hours.

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 facility has a current building warrant of fitness. There have been no changes required to the fire evacuation plan approved by the New Zealand Fire Service prior to the last audit. A code of compliance has been issued for the building work completed in January 2021.

Restraint minimisation and safe practice

| | | |
|---|--|--|
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
|---|--|--|

The organisation has implemented policies and procedures that support the minimisation of the use of restraints. Three residents have enablers in use and five residents have restraints in use at the time of audit. Restraint is used as a last resort and for the shortest duration able. Staff interviewed had a knowledge and understanding of Kumeu Village restraint and enabler processes and participate in relevant ongoing education.

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. |
|---|--|--|

Aged care specific surveillance is undertaken, data is analysed, and results reported and communicated to staff at the staff meetings. Follow-up action is taken 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 | 12 | 0 | 2 | 2 | 0 | 0 |
| Criteria | 0 | 34 | 0 | 2 | 3 | 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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | <p>Kumeu Village implements organisational policies and procedures to ensure the complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family members, the managers and staff reported their understanding of the complaints process and this aligns with the facility's policy. The complaints brochure is readily available in the main entrance.</p> <p>A complaints register is maintained. Fifteen concerns/complaints have been received since April 2020 and 20 written compliments. A review of four random sampled complaints verifies each was acknowledged, investigated, and responded to appropriately in a timely manner. There have been no complaints from the Ministry of Health, District Health Board or Health and Disability Commissioner since the last audit. Staff interviewed confirmed they would bring any resident or family member's concerns to the attention of the clinical manager, the RN on duty, or another member of the management team.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively with | FA | <p>Family members stated they were kept well informed about any changes to their relative's health status, were normally 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 sampled and in interviews conducted. In interviews conducted, residents and families expressed positive feedback on staff attitude, prompt response to residents' care needs and staff knowledge. Staff understood the principles of open disclosure, which is supported by policies and</p> |

| | | |
|---|----|--|
| consumers and provide an environment conducive to effective communication. | | <p>procedures. Personal, health and medical information is collected to facilitate the effective care of residents.</p> <p>There were no residents who required the services of an interpreter; however, staff knew how to access interpreter services if required. Interpreter services have been accessed to assist with communication and education of a staff member on occasions. Regular handovers at the beginning of each shift provide continuity of care. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>The objectives and quality improvement plan (2021/2022) detail the purpose, values, scope, goals, and objectives of the organisation. The service implements the Eden philosophy of care and is working towards achieving the final two (out of 10) Eden principals.</p> <p>The owner / director (and general manager), and the four other members of the management team monitor performance and progress towards achieving the goals. This includes via evaluating occupancy rates, staffing numbers, ongoing education/training, risks and issues, incidents and accidents, concerns / complaints and compliments, health and safety and other data reported via the balanced score card. The organisation's values are documented in staff job descriptions and discussed during staff orientation.</p> <p>The service is managed by the owner / director, who has almost 23 years' experience in providing aged related residential care (ARCC) including dementia care. Kumeu Village is one of three aged related residential care services currently owned by the owner/director. There is one other director who is not involved with day-to-day provision of services.</p> <p>The clinical manager was appointed to this role on the 1st of March 2021 in a temporary capacity while the permanent clinical manager has redeployed assisting with another facility on a temporary basis. Prior to being appointed as the temporary clinical manager, this staff member was the clinical nurse coordinator at Kumeu Village, and has over 11 years' experience working in the aged related residential care (ARCC) sector. The clinical manager is responsible for providing oversight of the clinical care provided to residents and ensuring their day-to-day care needs are met. The clinical manager has attended more than eight hours of relevant education in the past 12 months.</p> <p>A new operations manager was employed in November 2020 and has worked in various roles in the retirement village sector for approximately 10 years and is responsible for the non-clinical services.</p> <p>Residents live in 'households', with Kiwi, Fantail, Tuatara and Tui being the names given to the households where rest home and hospital level care is provided. There is a memory assist household for the care of 20 residents, and the vineyard villa for the care of 15 residents. The residents in Memory Assist and Vineyard Villa have been assessed as requiring dementia level care.</p> <p>Kumeu Village has an Aged Related Residential Care Contract with Waitemata District Health Board (WDHB) for</p> |

| | | |
|--|----|---|
| | | <p>the provision of rest home, hospital and dementia care services, and a Long-Term Conditions Chronic Health Contract (LTC CHC) contract. There is also a contract with the Ministry of Health for resident non aged services.</p> <p>All of the 63 rooms in the rest home and hospital area can be used for the care of either rest home or hospital level care residents. There is one room occupied by two residents (a couple). There were four residents at rest home level of care, with one other resident privately funding rest home level of care (has not yet had a formal needs assessment completed). There are 33 residents at dementia level of care, (with one resident under the MOH non-aged contract, and one resident receiving respite care), and 58 at hospital level care (including one resident under the MOH non aged contract, and one resident funded by Accident Compensation Corporation). There was a total of 96 residents receiving care at the time of audit. No residents were receiving care under the Long-Term Conditions Chronic Health Contract (LTC CHC) contract.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>Kumeu Village has a quality and risk management system which is understood and implemented by service providers. This is linked to the objectives and quality improvement plan, goals and the 'balanced score card data'. Quality related objectives are identified. The quality and risk programme includes compliments and complaints management, internal audits, satisfaction surveys, incident and accident reporting, hazard management, health and safety, restraint minimisation, infection control data collection and management. Regular internal audits are conducted, which cover relevant aspects of service including aspects of care including medication management, documentation, food services and the facility/equipment.</p> <p>Policies and procedures are available for staff electronically. These have been developed by an external consultant and then reviewed and localised to reflect the needs of Kumeu Village. Amended or new policies are circulated to all staff via the electronic patient management system. The quality manager is able to identify whether these are being reviewed by message recipients. The quality manager is responsible for document control processes. Policies and procedures are discussed where applicable during orientation and the staff education programme.</p> <p>A range of quality and risk activities are monitored monthly via the 'balanced score card', with the service identifying targets for aspects including occupancy, some financial aspects of service delivery/staffing, human resources, and care related indicators. The benchmark data is monitored monthly, and results reported via traffic light tables, and includes data for the previous month, previous three months, and previous year to enable comparison. The clinical manager is responsible for reviewing and ensuring action is taken for any clinical variances. An action plan has been developed in relation to the increased number of falls. There has been an increase in the use of staff sick leave. One likely contributing factor is the impact of Covid-19 and staff being cognisant of not coming to work if they have any concerns about their health status.</p> <p>A resident satisfaction survey is in process. There are 20 questions that are based on the Eden Philosophy of care. To date 28.9% of residents in the hospital and rest home wings have responded. Residents are unanimously satisfied with food services, safety, the personalisation of their room, trust in staff, privacy, are satisfied with staff attention and confirm being content. A staff satisfaction survey was conducted in 2020 and included 21 questions.</p> |

| | | |
|---|----|---|
| | | <p>The results have been evaluated and an action plan developed where applicable.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. 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 electronically. All staff interviewed confirmed they were kept informed of relevant quality and risk information including new or amended policies and procedures. Quality and risk activities and outcomes are also discussed at the weekly management meetings, the health and safety meetings (held two monthly), the registered nurses meeting (including the smaller household meetings held by the RNs). There are also regular meetings of the kitchen team and laundry team however these minutes were not reviewed. There is a residents' representative council, and a resident representative attends the staff meeting to discuss any issues or provide positive feedback and to advocate for the residents as required.</p> <p>Actual and potential hazards/risks are identified in the hazard register. The hazard register and mitigation strategies have been recently reviewed. Organisation risks are documented and reviewed at least annually or sooner where indicated. The general manager / owner discussed the issues related to the Covid-19 pandemic and initiated a range of precautionary measures before these were officially recommended.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.</p> <p>Applicable events are being reported electronically by staff. The registered nurse on duty is responsible for investigating the reported events and implementing any required care in a timely manner and disclosing the events to the resident and/or designated next of kin. Residents and family members interviewed confirmed they are kept informed in a timely manner. A review of reported events including for challenging behaviour, staff injury, falls, a skin tear, and a medication error demonstrated that incident reports are completed, investigated, and responded to in a timely manner. Staff advise they communicate any incidents and accidents to staff on the next shift during handover. The number and type of reported incidents/events have been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted. Applicable events are also discussed at the health and safety committee meeting.</p> <p>The three members of the management team interviewed on this topic could identify the types of events that are required to be reported as an essential notification to external agencies including the Ministry of Health. Notifications that have been made were discussed and included the changes in management and a fire in January 2020 (refer to 1.4.2.1). This has since been repaired with a code of compliance issued by Auckland City Council in January 2021, with a number of delays experienced because of the impact of various Covid-19 alert levels.</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>PA Moderate</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. Police vetting is inconsistently occurring, and reference and interview records are not consistently retained, and these aspects require improvement. The employment contract includes a statement advising staff of privacy / confidentiality requirements. Staff are required to read and sign the staff code of conduct / house rules.</p> <p>All employed and contracted registered health professionals have a current annual practising certificate (APC).</p> <p>Staff orientation includes all necessary components relevant to the role. This includes attending an orientation day with the quality manager who is also responsible for oversight of the staff training programme. These sessions are scheduled when there are five or more new staff. There is a manual/workbook that staff are provided that includes a checklist of activities to be signed off as completed, and a range of questionnaires to be completed. These are now being completed electronically. Staff reported that the orientation process included a period of being buddied with a senior staff member suitably prepared them for their role and responsibilities. Staff records reviewed showed new staff worked through or are in the process of completing orientation requirements. There is a comprehensive ongoing education programme that includes the Eden philosophy / components. Some staff working in the dementia care areas have not completed an industry approved qualification related to dementia care within ARRC contract timeframes. Some staff are overdue annual performance appraisals.</p> <p>There are a small number of volunteers assisting staff on occasions. Volunteers must complete an application form, and reference checks and police vetting occur. Volunteers are provided with an orientation.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).</p> <p>There are 10 registered nurses (RNs), and one enrolled nurse (EN) are employed, in addition to the quality manager and the clinical manager. There is always at least one registered nurse on duty, with normally two RNs on every morning and afternoon shifts, and an enrolled nurse who works in the memory assist household weekday mornings. The clinical manager and the quality manager are both registered nurses, with current interRAI competency, and they assist the other RNs with completing the interRAI assessments, and clinical care as required. The clinical manager and the quality manager work weekdays. There are five RNs who have current interRAI assessment competencies.</p> <p>Staff are rostered to work in specific households. Staffing is aligned with the Eden philosophy of care. During the day there are least two care partners who are on duty for the entire morning and afternoon shift in each of the four-rest home and hospital households, vineyard villa, and the memory assist unit. Additional staff are rostered in each household (except vineyard villa) with staggered start and /or finish times. There is a minimum of seven staff on duty overnight. This includes six care partners and one registered nurse.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and</p> |

| | | |
|--|--------|---|
| | | <p>family interviewed supported this. Observations and review of a roster cycle confirmed adequate staff cover has been provided, with staff replaced in most unplanned absences, unless determined to not be required. Agency staff are rarely used.</p> <p>At least one staff member on duty (normally more) has a current first aid certificate, and staff with current medicine competency rostered in each unit each shift. An afterhours on call roster of senior registered nurses / management team is in place, with staff reporting that good access to advice is available when needed.</p> <p>Laundry services are contracted out to an offsite laundromat. The resident and facility linen used in vineyard villa is washed by care partners throughout the 24-hour period.</p> <p>There are three staff in the life enhancement team facilitating the activities programme (refer 1.3.7), and two positions vacant and recruitment underway. There are two staff employed as animal carers (one full time and one part time), assisting residents looking after the resident's personal pets as well as the animals owned by Kumeu Village.</p> <p>Two staff are responsible for the facility, garden and maintenance activities, and three staff assist with administration duties.</p> <p>Six staff are employed in the cleaning team with allocated areas of responsibility and cover over the week (including weekends)</p> <p>A contracted physiotherapist is on site two to three days each week.</p> <p>Twelve staff work in the food services team. Food services are provided by employed staff and includes a cook working 5am to 1.30/2pm, and a second cook working 7.30 am to 5.30 pm every day. Two kitchen hands are also on duty per shift (two shifts) covering from 5am to 8.30pm every day.</p> <p>In addition to the two life enhancement team vacancies there are two care partner roles currently vacant. The CM is currently reviewing the list of casual care partners to confirm their ongoing availability.</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</p> | PA Low | <p>The medicine management policies and procedures clearly outline the service provider's responsibilities in relation to all stages of medicine management. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the registered nurses (RNs) when the resident is transferred back to service from hospital or any external appointments. Medication competencies were completed annually for all staff administering medication. There were no residents self-administering medicines at the time of the audit. Self-administration medication policy and procedure is in place when required.</p> <p>The name of the prescriber, dates of commencement and discontinuation of medicines were documented on the medicine charts sighted. The GP reviewed medicines within the required timeframes. Allergies were clearly indicated, and all residents' photos were current for easy identification. All expired medications were returned to the</p> |

| | | |
|---|--------|--|
| safe practice guidelines. | | <p>pharmacy in a timely manner.</p> <p>An improvement is required to consistently assess the effectiveness following pro re nata (PRN) medication administration.</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> | PA Low | <p>The food service is provided on site by four cooks who cover the working week. A chef manager was employed in January 2021. There are hot food choices available at lunch and dinner. There is a four-week summer and winter menu in use dated January 2019. Records are not available to demonstrate this has been reviewed by a registered dietitian.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Kumeu Village has a food control plan registered with Auckland City Council (expiry March 2022) and have been verified as being compliance with this with the most recent audit of food services occurring by Auckland City Council on 22 November 2020.</p> <p>Food temperatures, including high risk items are monitored appropriately and recorded. The chef manager interviewed has undertaken relevant food handling training, and records sighted demonstrating other applicable staff have completed food safety training. A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a nutritional profile is completed. Individual residents' dietary profiles are updated as required electronically or communicated verbally if urgent. The chef manager confirms having access to this information and a process is in place to check for changes daily. The personal preferences, any special diets and any modified texture requirements are made known to staff and accommodated in the daily menu plan. Residents in the secure dementia unit have access to a variety of food and fluids at all times. Special equipment to meet residents' needs is available.</p> <p>Evidence of food satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided including in the secure dementia unit.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p> | FA | <p>Some care plans reviewed evidenced that interventions were adequate to address the identified needs of residents, while some had insufficient detail (refer 1.3.3.3). Significant changes were reported in a timely manner and prescribed orders carried out. The clinical manager reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person centred. This was confirmed by the GP during interview. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs. One family member is paying for a private care partner 3-9pm daily to do whatever the resident wants to do as part of restraint minimisation activities.</p> |

| | | |
|--|----|---|
| desired outcomes. | | |
| <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> | FA | <p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by one diversional therapist (DT) and one activities (life enhancement) team coordinator. The operations manager reported that there are two vacancies and recruitment for two life enhancement team roles was in progress. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. These were completed within two weeks of admission in consultation with the family and residents. A monthly planner is developed, and each resident is given a copy of the planner that include a monthly birthday list. Daily activities were noted on the white board to remind residents and staff.</p> <p>The activity programme is formulated by the activities staff in consultation with residents and family/ whānau. The activities were varied and appropriate for people living with dementia, rest home and hospital level of care. Activities staff meetings were conducted monthly, and evidence of meeting minutes were sighted. Last meeting was held on 9 February 2021. Six monthly resident meetings were completed, and minutes of the meetings are given to management to consider and implement corrective action plans. Residents' activities care plans were evaluated following interRAI assessments, however some outcomes from interRAI assessments were not being consistently documented (refer 1.3.3.3).</p> <p>Weekly 24-hour activities overview in the memory assist unit and vineyard villa, the two units that house residents living with dementia reflect residents' preferred activities of choice and were evaluated every six months or as necessary. Residents are encouraged to participate in household chores under supervision of staff for safety and infection control practices.</p> <p>The Eden Alternative Philosophy is well incorporated into all services and continue to focus on life enhancement in totality including a strong focus on animal interaction, health, fitness, and overall wellbeing. The service has well maintained secure outside areas for residents to walk around and give them a chance to feed and pat the animals. Activity progress notes and activity attendance checklists are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate) however there were limitations during Covid-19 lockdowns. Family members and residents reported overall satisfaction with the level and variety of activities provided.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p> | FA | <p>Resident care is documented on each shift by care staff in the progress notes. All noted changes by the care partners were reported to the nursing team in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, occurs every six months or sooner if residents' needs change. However, outcomes from interRAI assessments were not being consistently addressed in the residents' lifestyle care plans and required interventions were not sufficiently detailed enough for some residents' care needs (refer 1.3.3.3). The evaluations were carried out by the RNs in</p> |

| | | |
|---|----|--|
| timely manner. | | <p>conjunction with family, residents, GPs', and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan. Resident records sampled evidenced that there were monitoring of; international normalized ratio (INR), fluid balance charts (intake and output), pain assessment, neurological observations post falls, and evaluation of a range of laboratory tests requested where clinically indicated.</p> <p>Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau were included and informed of all 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> | FA | <p>There was a current building warrant of fitness (BWOFF) with an expiry 20 February 2022. There have been no changes to the facility since the last audit except for repairs following a fire that occurred to the building housing the generator in January 2020. The Auckland City Council has issued a code of compliance for the completed work on 27 January 2021 (ref BCO10304429). There have been no changes to the approved fire evacuation plan in use at the last audit.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The clinical manager is the designated infection prevention and control coordinator (IP&CC) who is responsible for the infection control surveillance and reporting to management and staff any results on a monthly basis. Surveillance is appropriate to that recommended for long term care facilities and includes 17 types of infections, including of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. The IP&CC reviews all reported infections, and these were documented. Any new infections and any required management plan 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 surveillance are shared with staff via the staff meetings and at staff handovers. Graphs are produced that identify any trends by month, and the comparisons against previous month and follow-up actions required are noted. There have been no outbreaks of infection since the last audit.</p> <p>The GP confirmed staff bring any concerns about a resident with possible infection to the GP in a timely manner.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> | FA | <p>The organisation has implemented policies and procedures that support the minimisation of the use of restraints. Three residents have enablers in use and five residents have restraints in use at the time of audit. Restraint is used as a last resort and for the shortest duration able. The use of restraint and enablers is discussed at the monthly staff</p> |

| | | |
|--|--|---|
| <p>Services demonstrate that the use of restraint is actively minimised.</p> | | <p>meetings. A restraint and enabler register is maintained and this verifies that the use of restraint is discontinued when no longer required. One resident has six hours of privately funded care in the evening as part of an agreed plan with a resident's family so a resident can do whatever the resident wants to do with one-on-one supervision as part of restraint minimisation strategies. Staff interviewed had a knowledge and understanding of Kumeu Village restraint and enabler processes and participate in relevant ongoing education.</p> |
|--|--|---|

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|-------------------|---|---|---|
| Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | The recruitment process includes completing an application form and a health questionnaire, interviews (with a resident representative on the interview panel), referee checks, and validation of qualifications and practising certificates (APCs), where required. Reference and interview records are not consistently retained for five of the seven staff files reviewed who have been employed in since May 2020. Police vetting is occurring, although is inconsistent. While new staff are completing the police vetting authorisation form, these have not been actioned for six out of ten sampled staff. | Reference checks and interview records are not present in the personnel files for five out of seven staff employed since May 2020. Police vetting has not occurred for seven out of ten staff whose files | Ensure records are retained to demonstrate the recruitment process. Undertake police vetting for all staff during the employment process. |

| | | | | |
|---|------------------------|--|---|---|
| | | | were sampled. | 90 days |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | <p>PA Moderate</p> | <p>A comprehensive staff education programme is in place with in-service education identified and provided in block sessions starting 2021. This is to facilitate attendance with staff rostered to attend the mandatory training days. Ninety-nine staff attended the training day in January (block 1) that included complaints, open disclosure, advanced directives, infection prevention and control, health and safety, treaty of Waitangi, cultural safety and support, privacy/dignity, enduring power of attorney, abuse and neglect, waste management and quality and risk. The same day was repeated on four occasions to enable staff to attend. Block two in-service sessions occurred on the first day of the spot audit. The two-hour session included infection prevention and control, pandemic planning and fire and emergency procedures. The session was provided twice with further sessions scheduled for later in March 2021. The education plan includes all topics required to meet the ARRC contract and standards.</p> <p>Care partners are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Three staff have completed an industry approved qualification in dementia care, and three care partners are currently in training. Two staff have completed the dementia training course offered by a Tasmania University, however, are included in a group of 22 staff that filled in registration forms to complete the New Zealand qualification in the week prior to audit. There are six staff who have been working in the secure dementia services for longer than 18 months who have not completed the training requirements as required by the ARRC contract.</p> <p>Staff are required to have annual performance appraisal. This includes a self-appraisal component and a manager appraisal component. The appraisals are completed electronically. While some staff have current appraisals, a review of the appraisal information for 10 staff identified five staff have completed the self-appraisal component however, the line manager has not completed the requirements and for another staff member sampled neither the staff or managers appraisal information was recorded. Four of the sampled staff have a current appraisal. The appraisal list sighted noted that 32 staff had current appraisals as at the 5 January 2021 and managers have been allocated the staff they are responsible for completing the appraisals with.</p> | <p>Six staff working in the secure dementia service (Vineyard Villa and Memory Assist unit) for longer than 18 months have not completed an industry approved qualification in dementia care.</p> <p>Some staff are overdue performance appraisals.</p> | <p>Ensure all staff working with residents assessed as requiring secure dementia care complete an industry approved qualification within 18 months of employment in the applicable units.</p> <p>Undertake annual staff performance appraisal.</p> <p>90 days</p> |

| | | | | |
|--|-------------|---|---|---|
| | | | | |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | PA Low | <p>The care partner (CP) in the dementia wing and RN in the hospital wing were observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted. Monitoring of medicine fridge and room temperatures is conducted regularly and deviations from normal were reported and attended to promptly. The GP reviews medications every three months.</p> <p>The outcomes of PRN medicines administered were not being consistently documented.</p> | Effectiveness or outcomes of PRN medications administered were not always documented. | <p>Provide documented evidence of evaluation of administered of PRN medication.</p> <p>90 days</p> |
| <p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p> | PA Low | <p>The menu plans cover a four-week period and there is a winter and summer menu. These have not been reviewed by a registered dietitian to ensure the menu meets the nutritional requirements of older persons. Records were available to confirm a three-week summer and winter menu previously in use had been reviewed by a dietitian in November 2018, however this menu is not in use.</p> | Records are not available to demonstrate that the four-week summer menu in use dated January 2019 has been reviewed by a dietitian. | <p>Ensure the menu in use is reviewed by a dietitian to ensure the nutritional needs of residents are met.</p> <p>90 days</p> |
| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision</p> | PA Moderate | <p>InterRAI assessments and care plans were completed by the nursing team, diversional therapy (DT), activities coordinator and care staff were involved in the review process. This was confirmed by family/whānau and residents in interviews conducted. Some of the reviews completed did not meet time frames that safely</p> | (i) Outcomes identified during interRAI assessments | (i) Provide evidence that outcomes |

| | | | | |
|--|--|--|---|---|
| (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | | meet the needs of the residents or ARCC contract requirements. Outcomes identified during interRAI assessments were not consistently included in the care plan, or were insufficiently detailed in some sampled files. | <p>were not consistently included in the resident's care plan.</p> <p>(ii) The required interventions in the residents' care plans were not sufficiently detailed for some resident's needs.</p> <p>(iii) Three resident interRAI assessments were not completed within ARRC required timeframes. This was the initial assessment for a rest home resident and the ongoing assessments for two hospital level care residents.</p> | <p>from interRAI assessments are consistently included in the residents' care plans.</p> <p>(ii) Ensure interventions required are sufficiently detailed enough to address residents' care needs.</p> <p>(iii) Complete interRAI, initial and ongoing assessments within the required time frames.</p> <p>90 days</p> |
|--|--|--|---|---|

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.