# Taumarunui Community Kokiri Enterprises Limited

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Taumarunui Community Kokiri Enterprises Limited

**Premises audited:** Te Arahina O Arihia Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 6 October 2015 End date: 6 October 2015

**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:** 9

# 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 |
|  | 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

Te Arahina O Arihia Lifestyle Home has undergone some changes since the previous audit. The service exited the provision of dementia care on 1 September 2015, restructured staffing numbers and roles and reduced its capacity to provide rest home care to a maximum of 15 residents.

A new manager has been appointed and is working alongside the previous manager, whose role is clinical leader/registered nurse. The facility has changed its name to Te Arahina O Arihia Lifestyle Home. On the day of audit there were nine residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the providers’ contract with the District Health Board. The audit process included review of policy and procedures, review of resident and staff files, observations and interviews with residents, management, families and staff. A general practitioner (GP) was interviewed by telephone and expressed confidence in the staff and service delivery. The residents and family members interviewed stated they were very satisfied with the care and services provided.

There have been no coroner’s inquests or issues based audits since the previous certification audit in 2014. There are two improvements required as a result of this surveillance audit. These relate to medicine management systems and the regular evaluation of residents’ care and progress.

## Consumer rights

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| 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. |

There are effective communication systems between staff, between staff and residents and their families, and with other health providers. The service adheres to the practice of open disclosure where necessary.

Review of complaint records and interviews with staff, residents and families demonstrated that complaints received since the previous audit have been managed effectively. There have been no known complaints to the Office of the Health and Disability Commissioner (HDC).

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The service is maintaining its quality and risk management system with regular monitoring of all service areas.

Adverse events are reliably reported by all levels of staff. There have been no serious events requiring notification and there are effective systems to ensure regulatory requirements are met.

Human resources systems are in place and staff are recruited and managed effectively. Staff training in relevant subject areas is occurring regularly. All staff are supported and encouraged to attend ongoing performance development and achieve educational qualifications in health care. There has been a significant reduction in the number of staff employed and the number of hours allocated in some service areas, such as activities and cleaning, but the service meets the contractual requirements. There were adequate numbers of skilled and experienced care staff on site to meet the needs of residents 24 hours a day seven days a week.

## Continuum of service delivery

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| 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 low risk. |

The service promotes a team approach to care delivery and is coordinated in a manner that promotes continuity. Services are provided by suitably qualified and trained staff. All internal assessments of residents’ needs are completed using the electronic interRAI assessment programme. The processes for assessment, planning, provision, review and exit are provided within time frames that safely meet the needs of the resident and meet contractual requirements.

Care is evaluated at least six monthly, or sooner if there is a change in the resident’s needs, in which case, a short term care plan is implemented; however, an improvement is required to ensure that all care plans are evaluated to meet the required timeframes.

Residents are encouraged to maintain links with family and the community. The activities that the service provides within the rest home reflect this.

A safe medicine administration system was observed at the time of audit. Staff responsible for medicine management have been assessed as competent to do so. An improvement is required in the recording of the controlled medicines register and documentation of the reasons for administering of ‘as required’ medication.

The residents were satisfied with the meal service. The menu has been reviewed by a dietitian and residents’ nutritional requirements, preferences and needs are meet.

## Safe and appropriate environment

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| 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. The decommission of the provision of dementia care back to a single scope of rest home level care has not significantly impacted the environment. Apart from the removal of keypad access and security doors there were no structural changes to the building. Each bedroom is now allocated a sole occupant. The previous outsourcing of laundry services has stopped and staff now carry out laundry services. Improvements to the interior of the home were noted on the day of the audit. Emergency and disaster planning is evident and equipment and resources are available on site and maintained. All building regulations, fire safety, emergency and security standards are met. Residents and families interviewed are satisfied with the environment.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 restraint systems and practices meet the requirements of this standard. On the day of audit there were two residents using bed rails as enablers. Assessment, consent, approval and monitoring and review occurs in relation to the use of these interventions.

Staff training on restraint and enabler use continues to be provided regularly.

## Infection prevention and control

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| 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. |

Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in achieving infection reduction. The infection surveillance results are reported to staff and management in a timely manner.

## Summary of attainment

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

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| **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 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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 | The service continues to effectively manage the complaints process and maintain a complaints register. Residents interviewed confirmed knowledge of the ways to lodge a complaint. This was seen in the record of two complaints from residents logged since the previous audit. The documents show that each matter was investigated immediately, and managed effectively for resolution with all parties. There was evidence of ongoing communication with the people involved and external advocacy was offered. The complaint register contained many complaints from staff about other staff particularly while the service was undergoing change earlier this year and a temporary manager was in place. The documents reviewed and staff interviews confirmed that the matters were addressed in a professional and timely manner and were resolved. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The incident accident policy refers to open disclosure practices. Family/whanau confirm they are kept informed of the resident`s status and are notified of adverse events. Review of the incident accident and complaint records shows that contact with the family and GP is documented if the resident has been injured in an incident/accident or there has been any change in the resident’s condition. Details from doctors’ visits are documented and communicated as required. There were no residents for whom English is a second language. Staff know how to contact interpreter services if required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | On the day of this unannounced audit the facility had nine rest home level care residents. There were three residents whose care was subsidized as young people with disabilities and not under the Age Residential Care Contract.Interview with the new manager, RN and review of documents showed the quality, risk and business plans have current goals and that the board are provided with regular reports on service delivery and organisational performance. There has been significant change and restructure of the service to optimise sustainability. The new manager is the governing organisation’s HR manager and does not have experience in managing a care facility. This person has extensive experience in people management and employment. The previous manager is now full time employed as the clinical leader/RN. This person is attending ongoing performance development in subject areas related to the clinical leaders role. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Review of documents and staff interviews showed that the organisation is maintaining effective quality and risk management systems. Policies and procedures are updated as required to meet known best practice. Residents interviewed confirmed they are consulted about services and are being kept informed at regular residents’ meetings. All quality data, such as incidents/accidents, infections, results of internal audits, complaints and service delivery improvements continues to be analysed, presented at the larger organisation’s monthly quality assurance (QA) meetings and is discussed with the facility staff at daily handover or staff meetings. There is evidence of actions being implemented for good effect when service deficits are identified. The organisation's annual quality plan, business plan and associated emergency plans identify current actual and potential risk to the business, service delivery, staff and/or visitors’ health and safety. Environmental risks continue to be communicated to visitors, staff and residents as required. Review of staff meeting minutes showed that health and safety, including new hazards and resident related risks, are discussed. Trial fire evacuations have occurred every six months. |
| 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 | The adverse event reporting system is coordinated by the registered nurse (RN) and manager and known by staff who were interviewed. The event records reviewed showed that reporting occurs immediately and is investigated to determine cause and prevent or minimise recurrence. Service changes required as a result of the investigation are implemented as soon as practical. Staff, families and others who are impacted by an adverse event (eg, GP’s or DHB) are informed in a timely manner. This is recorded on the event form. Staff demonstrated understanding and knowledge about essential notification reporting. There have been no sentinel or other events which required 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.  | FA | The organisation is effectively managing its human resources. The skills and knowledge required is documented in position descriptions and employment agreements. The manager and a cross section of staff interviewed confirmed they understand their roles, delegated authority and responsibilities. Every job applicant is reference checked and police checked. Staff records contained evidence of curriculum vitaes (CVs), educational achievements, and the sole RN had a current practising certificate. New staff are oriented to organisational systems, quality and risk, the Code of Health and Disability Services Consumers’ Rights (the Code), health and safety, resident care, privacy and confidentiality, restraint, infection prevention and control and emergency situations. Individual staff performance appraisals are being conducted. Staff maintain knowledge and skills in emergency management, first aid certificates and competencies in medicine administration and attend regular training. The service supports all staff to engage in ongoing training and education related to care of older people.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The number of staff employed has been significantly reduced since the previous audit (from 22 FTE to 13 FTE and two casual staff). This was in response to the change in resident numbers and the single scope of rest home level care. Review of rosters and staff interviews revealed that the number of staff allocated to be on site in a 24 hour period meets the contractual requirements. There is a RN available on call 24 hours a day seven days a week. The activities coordinator is on site Monday to Friday from 10 am to 1 pm and for longer periods if this is required for outings. A dedicated cleaner is employed for 15 hours per week, Monday to Friday and staff carry out laundry services and cleaning where required on all shifts. Residents and family are satisfied with the availability of staff.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of the audit. Medicines were stored in a locked medicine trolley and stored in a locked room in the rest home. The controlled medicines register was sighted; one medication balance of a discharged resident, who was receiving respite care, was incorrect. The nine medicine charts reviewed have been reviewed by the GP every three months as was recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and ‘as required’ (prn) medications identified, however eight of the nine medicine charts did not have the prn medications reason stated and identified for the use of that medication. There is a specimen signature register maintained for all staff who administer medicines. Medicine files reviewed have a photo of the resident to assist with the identification of the resident and recorded any medicine related allergies. The registered nurse reported that no residents are self-medicating.There are documented competencies sighted for the staff (registered nurse and caregivers) designated as responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management. For the fridge in the rest home where the insulin is stored correct temperatures were sighted.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a four week rotating menu throughout the summer and winter season. The menu is created in discussion with residents and then reviewed by a dietitian. When unintentional weight loss or weight gain is recorded, the resident is discussed with the GP and referred for a dietitian review. A nutritional profile is completed for each resident by the registered nurse upon entry to the service and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.Residents are encouraged to have all meals in two dining rooms available but have the option of eating meals in their rooms. All meals are cooked and served directly from the kitchen. Family/whanau and residents interviewed reported that they are satisfied with the meals provided.Regular monitoring and surveillance of food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal were sighted at the time of audit. All fridges and freezers had temperature recordings sighted. Kitchen staff have undertaken food safety management education appropriate to service delivery. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The care plans reviewed in the rest home were individualised and reflected the needs of each resident. Observations on the day of audit demonstrated that residents were receiving care that is flexible and focused on promoting quality of life for the resident. The GP expressed satisfaction with the care provided and reported that the staff were knowledgeable and appropriately skilled. The registered nurse and caregivers interviewed reported that the care plans were accurate and kept up to date to reflect the resident’s needs.Residents and family/whanau interviewed reported high satisfaction with the care and service delivery. |
| Standard 1.3.7: Planned ActivitiesWhere 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 covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on events that are organised within the township and surrounding communities. Regular activities include discussing of current affairs, church services, van outings, specific men’s and women’s groups, arts and crafts, happy hour and regular weekly entertainment. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activity coordinators adapt activities to meet the needs and choices of the resident. The daily and monthly activities plan sighted was developed based on the residents’ needs, skills and strengths and is developed in discussion with residents. The service provides easy access to outside courtside areas. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | Two of six residents care plans sighted had not been evaluated six monthly as required. When there are short term care plans, these interventions are evaluated more frequently. The wound treatment plan sighted has an evaluation of the treatment and condition of the wound at each dressing changes. If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. The residents and family/whanau reported high satisfaction with the care provided at the service and stated that they can consult with the staff at any time if they have concerns or there are changes in the resident’s condition. |
| 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 of warrant of fitness which expires in May 2016. Hazard monitoring and preventative maintenance occurs. New carpeting was due to be laid on the day of the audit and room upgrades and internal painting has happened since the previous audit. All external areas are safe. The decommissioning of the secure unit between July and September 2015 did not require any structural changes to the building. All bedrooms are now single occupancy whereby previously a number of them were double/shared rooms.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection coordinator completes monthly surveillance of infections and uses standardised definitions of infections that are appropriate to the long term care setting. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infection. Trends and/or concerns about a resident are identified and these are discussed at staff meetings and at staff handovers where additional actions are discussed and implemented. The surveillance data for 2015 shows a very low infection rate. Benchmarking is not occurring at time of audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Two residents were using bed rails as enablers on the day of the audit. Discussions with the restraint coordinator and review of residents’ records and restraint documentation revealed that assessment and consent had been obtained and that monitoring and quality evaluation and review of all restraints and enablers is occurring. The service complies with this standard.  |

# 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 1.3.12.1A 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. | PA Low | A medicine administration round was observed on the day of the audit and best practice was sighted. Medicine records of nine residents were reviewed and the controlled medicines register was sighted, Documentation required as per legislation was not always evident.  | The controlled medicines register showed a recorded balance of controlled medications that were not on site at the time of audit. The medications had been returned to the (respite) resident on discharge home but the medications had not been signed out of the register. Eight of nine medicine charts did not have the reasons required for administering prn (as required) medicines.  | Ensure adherence to safe medicines administration guidelines.180 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Staff report on residents care and goals in progress notes at least daily. Relevant changes are made to care plans; however two of six residents care plans sampled have not been evaluated within the required timeframe of six months. | Two of six residents care plans sampled had not been evaluated within required timeframe of six months. | Ensure residents’ cares and progress is evaluated at least six monthly as stated in policy and contractual requirements.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.

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End of the report.