# Kena Kena Rest Home 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 Health Audit (NZ) 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:** Kena Kena Rest Home Limited

**Premises audited:** Kena Kena Rest Home

**Services audited:** Rest home care (excluding dementia care); Residential disability services - Physical

**Dates of audit:** Start date: 7 March 2016 End date: 7 March 2016

**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:** 40

# 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

Kena Kena Rest Home is certified to provide rest home level care for up to 41 residents. There have been no changes in the governance or management since the last certification audit.

This surveillance audit was conducted to assess on going compliance with the Health and Disability Standards and the contract with the district health board (DHB). The audit process included a review of policies and procedures, sampling of both resident and staff files, observations, interviews with residents, family, management, governance representatives, staff and a general practitioner (GP).

There were no areas of non-conformance identified during the audit.

## 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. |

Residents and family report that they are given sufficient information regarding the services they are to receive and feel informed. Management has an open door policy. Information regarding the services available is provided and resident satisfactions surveys are conducted. There is evidence that family are notified as required. The complaints process is accessible and a complaints register is maintained.

## 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. |

There is a documented quality and risk management system. The required policies and procedures are documented and current. Organisational performance is monitored by the directors. Quality activities ensure that improvements are made in a continual manner. Adverse events are well managed and monitored for trends. Human resource processes ensure that there are suitable number of trained staff on duty at all times. Staff numbers are sufficient to ensure the needs of residents are met over the 24 hour period.

## 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. |  | Standards applicable to this service fully attained. |

Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and evaluated in a timely manner. Interventions are sufficiently detailed to address the care needs. Short term care plans are developed when acute conditions are identified and resolutions are documented.

Planned activities are appropriate to the needs, age and culture of the residents who reported that activities are enjoyable and meaningful to them.

The medicine management system meets the required regulations and guidelines. Medication competencies are maintained.

Food services meet food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met.

## 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. |

There is a current building warrant of fitness and there have been no changes to the facility since the last certification audit.

## 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. |

Policies and procedures identify the safe use of restraints and enablers which are utilised as the least restrictive option and allow the residents to maintain independence, comfort and safety.

## 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. |

Infection control surveillance activities are appropriate to the size and scope of the service.

## 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 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 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 complaints process complies with Right 10 of the Code. All residents are given information regarding the complaints process. Complaint forms are easily accessible and residents interviewed reported they would use the complaints process if required. A complaints register is maintained. There have been two documented complaints since the last certification audit. Records sampled confirmed that they had been well managed, and resolved to the satisfaction of the complainant. Opportunities for improvement are made as required. Complaints are fully discussed at the quality assurance meetings. Resident meetings are also conducted and these provide opportunities for residents to verbalise any day to day concerns.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy. Discussions with residents and their family members are documented in residents’ records. Resident and relative satisfaction surveys confirmed that the organisation is committed to sharing information in an open manner. Residents are given information regarding the services they will receive, including any additional costs, during the admission process. Resident agreements comply with district health board requirements. Residents interviewed confirmed that they are aware of the staff that are responsible for their care for the day and what the programme for the day will include. The facility manager reported that access to interpreter services is available 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 | There have been no changes to the governance or management structure since the last audit. A business plan and a quality and risk management plan are documented, as is the mission statement, values, vision and objectives. Organisation performance is monitored by the directors. There are appropriate systems in place to ensure day-to-day operations continue should the facility manager (FM) and/or the clinical manager (CM) be absent. Both are registered nurses with a current annual practicing certificate and maintain their clinical scope of practice. The organisational chart confirms reporting lines within the organisation.The rest home is currently certified to provide 41 rest home and residential disability care beds for residents under the age of 65. The rest home also has a contract with the district health board for long term support – chronic health conditions. There were 40 residents on the day of the audit. This included one resident under 65 and one resident admitted under long term care. The remaining residents were assessed as requiring rest home level care.  |
| 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 | There is a documented quality and risk management system. Policies and procedures are purchased from an external consultant and are relevant to the scope and complexity of the service. Policies and procedures are updated as required to reflect current good practice, and reference legislative requirements. All policies and procedures sighted were current and controlled. There is a system for managing obsolete documents.A range of business activities are conducted. The managers have an annual meeting with the accountant to discuss business plans and goals for the coming year. Quality goals are identified in measurable terms. Achievement towards quality goals is measured through satisfaction surveys, internal audits and monitoring of clinical outcomes. The internal audit programme covers the scope of the system and there is evidence that corrective actions are identified, implemented and evaluated. A register (summary) of continuous quality improvement (CQI) auditing activity results is maintained. Business, clinical and quality data is collated and discussed at quality meetings. This includes the results of surveys, complaints, infection control surveillance, health and safety, restraint and adverse events. Organisational and clinical risks are identified. Risks are discussed at staff and quality meetings. A health and safety programme is implemented including the management of hazards. Management interviewed were well versed in their responsibilities under the amended work safe legislation. |
| 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 | Records on all adverse events are maintained. Accident and incident forms are forwarded to either the facility manager (FM) or the clinical manager (CM) for follow up. Records of incident reports sampled confirmed appropriate and timely immediate actions, followed by an investigation. Where required a corrective action plan is developed and evaluated. There is evidence that the family and general practitioner (GP) are notified as required and the managers understand their obligations in relation to additional essential notifications. Adverse events are collated by type and graphed for trends. Information on adverse events is discussed at quality management meetings. Adverse events policies and procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control).  |
| 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 | Human resource policies and procedures comply with good employment practice. The skills and knowledge required for each position is documented in position descriptions which outline accountability, responsibilities and authority. The two registered nurses maintain their annual practicing certificate and all care givers have a qualification in working with the older person. All staff receive an orientation. The orientation programme includes the essential components of service delivery. The required orientation records were sighted in staff records sampled.The clinical manager is responsible for the in-service education programme. The education planner includes the requirements of this standard and the district health board contract. Individual staff attendance records were sampled and confirmed the provision of the scheduled programme. Competency assessments are also completed, for example restraint competencies and medication competencies. Additional training is accessed as required or available. A number of staff have a current first aid certificate. Staff performance is monitored. All staff have an annual performance appraisal. Appraisals were sighted in the staff records sampled. Care staff interviewed confirmed they have completed an orientation, including competency assessments (as required).  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mixes. There is a registered nurse on site seven days a week between 7am and 5.30pm with on call support 24 hours a day, seven days a week. Each of the three wings is staffed by care givers, with two staff on duty during the night. There is at least one staff member with a current first aid certificate on each shift. Residents and family interviewed reported that staff are available when needed. Rosters sampled confirmed sufficient cover. This included staff replacement in the event of absence. It is reported that bureau staff are rarely required.  |
| 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. | FA | A medicine management system is implemented to ensure safe delivery of medicines to the residents. Allergies and indications of medicines are documented. Medication records are reviewed every three months. Weekly and six-monthly controlled drugs stocktakes are conducted. The controlled drugs register was correct and current. The medication fridge is monitored and the temperature is recorded daily. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored appropriately.The staff administering the lunchtime medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled.There were no residents who self-administered medications on audit day. Policies and procedures are in place to ensure safe storage and compliance in relation to self-administration of medications. |
| 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 | All meals are prepared and cooked onsite. Cooked meals are plated from the kitchen to the main dining area. Fridge and food temperatures are monitored and recorded daily. There is evidence that the current menu is reviewed every two years by a dietician. Food service policies and procedures are in place and implemented. A system is in place when receiving and utilising supplies. Staff working in the kitchen have current food handling certificates. A kitchen cleaning schedule is in place.Residents are provided with meals that meet their desired food, fluids and nutritional needs. Dietary forms are completed by the manager on admission and a copy is provided to the kitchen. Modified foods are provided to the residents when required. The meals are well-presented and the residents reported that they are provided with alternative meals as per request. Residents have stable weights and residents with weight changes are provided with food supplements or fortified meals. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Long and short term care plans are developed by the RNs. Interventions in both long and short term care plans are sufficiently detailed to address the desired goals/outcomes. Documented interventions are simple, practical and staff reported they are easy to follow.Monitoring forms are in use as applicable, such as weight, vital signs, wounds and behaviour.Wound assessment, monitoring and wound management plans are in place for residents, who require them. The RNs have access to specialist services when needed. Referrals are initiated by the GP or by the manager. |
| 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 | Activities provided for the residents are appropriate to their needs, age and culture. Activity plans are developed by the diversional therapist (DT) using the resident’s profile gathered during the interview with the resident and their family. Activities are developed to be physically and mentally stimulating. There is one diversional therapist assistant working with the DT.All residents are provided with a monthly activities programme while weekly activities are posted in communal areas. A participation log is maintained by the DT or DT assistant and residents are referred to the RNs when involvement in activities changes. Interviewed residents and their families reported satisfaction with the activities provided. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long and short term care plans are evaluated in a comprehensive and timely manner. Evaluations include the resident’s degree of achievement towards meeting the desired goals/outcomes. Resident’s response to the treatment regime in the short term care plan is documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. |
| 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 have been no changes to the facility since the last certification audit. A current building warrant of fitness was sighted. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved evacuation plan. Evacuation drills are conducted as required.  |
| 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 | Surveillance for infection is conducted in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. The infection control coordinator is responsible for the surveillance programme. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented. Information is collated on a monthly basis and documented in the infection log. Data is trended and infections are investigated. Surveillance results are discussed in the quality assurance meetings. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service demonstrated that the use of restraint is utilised as a last resort in providing safety and comfort to the residents. There were two residents using restraints and no residents using enablers. The restraint register is current and updated. Risk management plans are in place to minimise restraint-related injuries. Restraint minimisation policies and procedures are in place, and include definitions, processes and the safe use of restraints and enablers. Staff demonstrated good knowledge regarding restraints and enablers. |

# 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.

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| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.