# Residential Management Limited - Tereance Kennedy House

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:** Residential Management Limited

**Premises audited:** Terence Kennedy House

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 6 April 2017 End date: 7 April 2017

**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:** 41

# 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

Terence Kennedy House provides rest home and hospital level care for up to 45 residents. On the day of the audit there were 41 residents. The service is managed by an experienced manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

The service is commended for achieving a continued improvement rating around best practice for the falls reduction project.

This audit has identified the following areas requiring improvement: corrective actions, and interventions.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Staff at Terence Kennedy House strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Cultural needs of residents are met. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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

The quality and risk management programme includes service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. A comprehensive education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## 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 low risk. |

Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed demonstrate service integration and are evaluated at least six-monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations. Residents and families report satisfaction with the activities programme.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

The building has a current warrant of fitness and emergency evacuation plan. Rooms are individualised. There are large spacious lounges and dining areas. There are adequate toilets and showers. The internal areas are able to be ventilated and heated. There is sufficient space to allow the movement of residents around the facility using mobility aids. The outdoor areas are safe and easily accessible. Cleaning services are monitored through the internal auditing system. Laundry is completed on-site by dedicated laundry staff.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency.

## 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. |

Terrence Kennedy House has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were two residents with restraint and three residents with an enabler. Restraint management processes are adhered to.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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** | 1 | 46 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 1 | 97 | 0 | 3 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](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).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (five healthcare assistants, two registered nurses (RN), one activities coordinators, one facility manager and one general manager) confirm their familiarity with the Code. Interviews with nine residents (seven rest home and two hospital) and four families (three rest home and one hospital) confirm the services are being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings.  Code of Rights training including advocacy, informed consent, privacy and prevention of elderly abuse, are part of the mandatory training days that staff undertake which are facilitated twice a year to ensure all staff attend. This was held in March 2017. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their power of attorney signs written consents. Seven resident files reviewed (four hospital- including one long term chronic care and three rest home -including one respite), demonstrate that advanced directives are signed for. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All resident files sampled have a signed admission agreement signed on or before the day of admission and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Staff and residents informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to be involved in community activities and maintain family and friend’s networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of complaints process. There are complaint forms available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaint register. Verbal and written complaints are documented. There have been five complaints in 2017 year to date. The complaint documentation was reviewed for all five complaints. All had documented investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the facility manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident’s privacy and can describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs are met.  There is a policy that describes spiritual care. Church services are conducted every Sunday. All residents interviewed indicated that resident’s spiritual needs are being met when required. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There were no residents who identified as Māori on the day of the audit.  Discussions with staff confirm that they are aware of the need to respond to cultural differences and described how they would document the care plans for the specific cultural requirements of Māori residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service has established cultural policies aimed at meeting the cultural needs of its residents. All residents interviewed report that they are satisfied that their cultural and individual values are being met.  Information gathered during assessment including resident’s cultural beliefs and values, is used to develop a care plan, which the resident and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness (mandatory training day in March 2017). |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed report that the staff respect them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | The service has policies that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey was sent out in March 2017 and the 28 completed survey forms returned have not yet been fully analysed. Overall, the survey forms sighted demonstrate high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed have a sound understanding of principles of aged care and state that they feel supported by the management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eight incidents/accidents forms were reviewed. The forms included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Terence Kennedy House is an aged care facility located in West Auckland. There are 45 dual purpose rest home and hospital level beds. On the day of the audit there were 41 residents. There were eight rest home level residents, including one respite resident and thirty-three hospital level residents, including two residents admitted under the long term chronic and one resident admitted under an ACC contract.  A business plan is in place for 2017. A mission, philosophy and objectives are documented for the service. The manager completes a weekly report for the general manager and then meets at least weekly to review the day to day operations and to review progress towards meeting the business objectives.  The manager has 28 years of management experience in the aged care sector. The manager has been in her role at this facility for six months and is supported by a clinical manager/registered nurse (RN) and thirty-eight staff. The manager has maintained a minimum of eight hours of professional development relating to managing an aged care service. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the facility manager, the clinical manager is in charge with support from the general manager and the other care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management programme is in place. Interviews with the general manager, facility manager, care staff and one cook, one maintenance and one laundry staff member reflected their understanding of the quality and risk management systems that are in place.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are expected to sign that they have read the new/revised policies.  Quality management systems are in place including: internal audits; incident and accident reporting; health and safety reporting; infection control data; and complaints management. Data is being collected monthly but is not consistently communicated to staff. Corrective actions are not consistently documented, reviewed or communicated to staff.  A number of quality improvements have been made since the last audit including: updating the phone system; installing a new nurse call system; replacing the vinyl in the main dining room; and implementing a new quality management system.  A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (a registered nurse) and review of health and safety documentation confirms that legislative requirements are being met. External contractors have been orientated to the facility’s health and safety programme. The hazard register is regularly reviewed (last review 14 January 2017). |
| 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 | There is an accidents and incidents reporting policy. The facility manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings. A registered nurse conducts clinical follow up of residents. Eight incident forms sampled from March 2017 did not always demonstrate that appropriate clinical follow up and investigation occurred following incidents (link 1.3.5.2). Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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 | There are human resources management policies in place. A copy of practising certificates is kept. Seven staff files were reviewed (one clinical manager, one registered nurse, one activities coordinator, one cook, one laundry and two healthcare assistants) and all evidence that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2016 has been reviewed and a plan for 2017 is being implemented. The facility manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Four of the seven registered nurses have completed interRAI training. Annual staff appraisals are evident in all staff files reviewed. |
| 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 policy includes a staffing rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager is on-site Monday to Friday and is on call after hours.  There is one clinical manager and one registered nurse on a morning shift and one registered nurse on an afternoon and night shift. There are seven healthcare assistants on a morning shift and five healthcare assistants on an afternoon shift. There are two healthcare assistants on a night shift. Extra staff can be called in for increased resident requirements.  Activities staff are rostered on five days per week. There are separate domestic staff that are responsible for cleaning and laundry services.  Interviews with staff, residents and family members confirms that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy.  The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the Age Related Residential Care Services Agreement. Exclusions from the service are included in the admission agreement. Six out of seven admission agreements viewed were signed and dated. One respite agreement is currently with the family to be signed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. Respite residents have their discharge recorded in the progress notes. |
| 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 | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There are currently no residents self-medicating. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses who have passed their medication competency administer medications. Medication competencies are updated annually and staff attend annual education. There are standing orders and these meet legal requirements. The medication fridge temperature is checked daily. All medication is stored securely. Eye drops are dated once opened.  Staff sign for the administration of medications on medication administration sheets.  Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. All medication charts include a photo ID and allergy status. As required medications have indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Terrence Kennedy House are prepared and cooked on-site. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Meals are plated in the kitchen and then served in the two dining rooms. End cooked meals and fridge and freezer temperatures are recorded.  Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met. There is a system to identify residents who require monitoring of food intake. Specialised crockery and utensils are available to help promote independence at meal times.  Residents were observed enjoying their lunch in one dining room and a healthcare assistant was observed assisting a resident to eat in another. Residents’ meetings allow for the opportunity for resident feedback on the meals and food services. Residents are complimentary of the food and confirm that alternative food choices are offered for dislikes.  All staff who work in the kitchen have completed food safety and hygiene and chemical safety training. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicate that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contain appropriate assessment tools and assessments are reviewed at least six-monthly or when there is a change to a resident’s health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all long-term residents. Care plans sampled have been developed on the basis of these assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Care plans reviewed evidence multidisciplinary involvement in the care of the resident. All care plans are resident centred; however care plan interventions were not documented for two residents with a history of wandering off site, who were newly admitted residents to the facility. Residents interviewed stated they are involved in the care planning process.  Short-term care plans are in use for changes in health status and have been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan as needed. There is evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, physiotherapist, dietitian and Mental Health Care Team for Older People. The care staff interviewed advised that the care plans are easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Care plans are in place for all residents. When a resident’s condition changes, the RN will initiate a GP consultation. Staff state that they notify family members about any changes in their relative’s health status. Care plans had been updated as residents’ needs changed.  Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted.  Wound assessment, wound management and evaluation forms are available for all wounds. Wound monitoring occurred as planned. There is currently one wound (a right lateral leg skin tear category one) and one stage I pressure injury. There is also a protective dressing on a healed sacral pressure injury. The facility has access to wound care specialist advice if required.  Monitoring forms are in use as applicable such as: weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviour. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is one activities coordinator who works 25 hours a week. On the days of audit, residents were observed taking part in exercises and playing ‘toss the frog’. They have recently been busy with Easter crafts.  There is a monthly large print programme on the noticeboard. Residents have the choice of a variety of activities in which to participate. These include exercises, games, crafts, painting, pet therapy and quizzes.  Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat. The activities coordinator may take the residents books, puzzles or crosswords. A volunteer assists the activities coordinator with one-on-one visits.  There is fortnightly church services by the Salvation Army and an interdenominational group. Volunteers from the local Catholic Church come weekly to give communion.  The facility uses the village van for weekly outings. Every Thursday a local playgroup visits. There are also regular entertainers visiting the facility. Special events such as birthdays, Easter, Mothers’ Day and Anzac Day are celebrated.  There is a resident meeting monthly and an annual residents’ satisfaction survey.  Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identify that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The six long-term care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short term needs had been evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each resident and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home residents and one-monthly for hospital residents. The family members interviewed confirm that they are informed of any changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of a resident being referred to the Mental Health Team for Older People. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff are aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety data sheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current building warrant of fitness (30 October 2017). The person responsible for the village maintenance also oversees the reactive and planned maintenance programme for the care facility. All medical and electrical equipment has been recently serviced and/or calibrated. Hot water temperatures are monitored, however not all water temperatures in resident areas are below 45 degrees Celsius. The facility has endeavoured to rectify the fluctuation of temperatures over many years. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms have an ensuite with toilet and shower facilities. Toilets are located close to dining rooms and lounges for residents use. A visitor’s toilet is available. Residents interviewed confirm their privacy is assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents’ rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is one large lounge, one large dining area and one smaller lounge/dining area. There is one large library area. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were observed to be moving freely both with and without assistance throughout the audit. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are dedicated cleaning staff at the service. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed are satisfied with the standard of cleanliness in the facility.  There are dedicated laundry staff who complete all laundry on-site in an appropriately appointed laundry. Residents interviewed are satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.  There are call bells in the residents’ rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Terence Kennedy House has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the Infection Control Committee and all other staff. Infection control is an agenda item at the monthly staff meetings. Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse at Terence Kennedy is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC Committee (comprising the facility manager, registered nurse, cook and healthcare assistants) have external support from the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are Terence Kennedy House infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has a level seven qualification in infection control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Kennedy House’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. Two hospital residents were using restraint (bedrails) and three hospital residents were using enablers (bedrails) on the day of audit. Assessments were completed and written consent was provided by the three residents using enablers.  Staff interviews confirms their understanding of the differences between a restraint and an enabler.  Staff receive regular training around restraint minimisation and the management of challenging behaviour that begins during their induction to the service. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require restraint or enabler interventions. These have been undertaken by suitably qualified and skilled staff, in partnership with the family/whānau in the two restraint and two enabler files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the files reviewed, assessments and consents are fully completed. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed have a completed assessment form and a care plan that reflect risk. In resident files reviewed, appropriate monitoring and documentation has been completed. The service has a restraint and enabler register which is updated each month. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every three months. In the files reviewed, evaluations have been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly staff meetings. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The service captures quality data (falls, skin tears, medication errors, infections, accident and incident and compliments/complaints). Where areas requiring improvements were noted, corrective action plans were documented. Not all corrective action plans have been reviewed and signed out once completed. Not all results of audits and the corrective action plans developed have been communicated to staff. | i) The results of audits and corrective action plans are not consistently being communicated to staff.  ii) Not all corrective action plans documented are reviewed and signed out once completed. | i) Ensure that the results of audits and corrective action plans are consistently communicated to staff.  ii) Ensure that all corrective action plans are reviewed and signed out once completed.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | The RN reviews information gathered from assessments, monitoring charts, observations, interviews with residents, staff and families to develop the care plan. Care plan interventions had not been documented for two residents with a recent history of wandering. These care plan interventions were completed on the day of audit. | Two of two hospital residents with a recent history of wandering off-site, did not have interventions documented to manage this risk. Staff were aware of the risk and increased monitoring was occurring. Care plan interventions were updated during the audit and therefore the risk has been identified as low. | Ensure that care plan interventions are documented for all identified care needs.  30 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The physical environment is maintained. There is a planned and reactive maintenance programme in place. The interior of the building will be repainted in the coming months and the carpet in the corridors will be replaced. The external areas are well maintained. Hot water temperatures are monitored at least monthly and more frequently when temperatures fluctuate. Not all hot water temperatures in resident areas are below 45 degrees. They have initiated interventions regarding the matter of the fluctuation of hot water temperatures, including (but not limited to) calling a plumber to review the hot water system on several occasions; and replacing the tempering valves. However, the water temperatures at some resident hand basins remain between 45 and 53 degrees Celsius. The plumber has stated there is nothing more they can do. | Thirty-two of forty-five hand basins in resident bedrooms have hot water temperatures recorded from 46 – 54 degrees Celsius. The service was able to demonstrate ongoing attempts to rectify the issue, including having a signed statement from Plumber stating all has been done to rectify this matter; consideration to the fact no incident/accident has been reported relating to hot water temperature; discussed at staff and resident meetings and renewal of warning signs at each of our resident room sinks. | Ensure that hot water temperatures in resident areas continue to be monitored and managed to minimise risk when exceed 45 degrees Celsius.  90 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The service has implemented a quality and risk management system and captures a range of quality data. The service analyses this data to identify areas for improvement. The service reviewed the clinical indicator data in January 2016 and identified that the incidence of falls was too high. A project was implemented to reduce the overall falls rate. This project included the purchase of additional equipment, replacement of some floor coverings, education for staff and residents and a change to clinical practice. | Analysis of the falls data in January 2016 evidenced that the number of falls occurring were above an acceptable benchmark. The service initiated a project to reduce the number of falls.  Additional education was provided to the staff and the residents (where appropriate) on how to prevent falls. Non-slip vinyl was installed in high fall areas and additional low beds and sensor mats were provided. The roster was altered to allow for additional staff cover during staff handover and intentional rounding process was implemented. The resident’s care plans were amended to include falls prevention strategies and the residents were toileted more frequently. Toolbox talks were regularly provided to staff on the importance of observing the residents at risk of falling. Falls data was reviewed regularly at staff meetings. The general practitioners (GP) was asked to review the medication for all frequent fallers.  As a result of these actions, the incidence of falls steadily reduced from twenty-three falls in January 2016 to five falls in March 2017. |

End of the report.