# Real Living (Services) Limited

## 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:** Real Living (Services) Limited

**Premises audited:** Kensington House

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

**Dates of audit:** Start date: 14 April 2015 End date: 15 April 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:** 30

# 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

Kensington House is a privately owned aged care facility. The service is governed by a shared trust board. Kensington House provides care to up to 32 rest home level residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

There are well developed systems that are structured to provide appropriate quality care for residents. Quality and risk management programme is individualised. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. There are quality systems and processes implemented.

The service is managed by an experienced aged care nurse manager who has been in the role since 2001. The manager is supported by registered nurses. Residents and families interviewed were very complimentary of care and support provided and their involvement in the on-going care and the congenial atmosphere of the rest home.

Improvements are required in relation to adverse event reporting, one aspect of care planning and aspects of medication documentation.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The staff at Kensington House ensures 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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. Complaints and concerns have been managed 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. |  | Some standards applicable to this service partially attained and of low risk. |

Kensington House has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing internal collated data. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme.

The service’s medication management policies and procedures follow recognised standards and guidelines for safe medicine management practice. All meals and baking are prepared and cooked on-site. Residents' food preferences and dietary requirements are identified at admission. This includes consideration of any particular dietary preferences or needs.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

Kensington House has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their own rooms. There are sufficient communal areas within the facility including a very large lounge opening onto a patio area and landscaped gardens, dining areas, and a well-appointed sunroom. There is a designated laundry and cleaner’s cupboard. All key staff have current first aid certificates. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided.

## 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. |

There is a restraint policy that includes comprehensive restraint procedures and aligns with the standards. The service has a restraint free philosophy and there are no restraints or enablers used. All staff has had training around restraint, enablers and management of challenging behaviours.

## 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 management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 42 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 2 | 1 | 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 | Discussions with staff (three registered nurses and three caregivers) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Six residents and four relatives interviewed confirmed the services being provided are in line with the Code. |
| 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 and advanced directives were recorded as evidenced in the six resident files reviewed. Staff advised that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. |
| 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 and relatives confirmed that visiting can occur at any time. Key people involved in the resident’s life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is maintained. Systems and processes are in place to ensure that any complaint received is managed and resolved appropriately. There were three complaints in 2014 and four received to date in 2015. Complaints recorded are verbal or written. All complaints have been managed with resolution documented. The service records and deals with minor concerns in a separate book. Residents and family members advised that they are aware of the complaints procedure and how to access forms. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well-informed about the code of rights. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and is available at reception. |
| 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 | Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident’s privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment.  Church services are held monthly and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided. |
| 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 a Maori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There are currently no residents at Kensington House who identify as Maori. The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. |
| 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 | Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. One of the registered nurses (has been employed for 16 years) and the nurse manager is responsible for coordinating the internal audit programme. A variety of staff meetings and residents meetings are conducted.  Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the nurse manager. Care staff complete competencies relevant to their practice. Three of the caregivers have gained a qualification in aged care and it is a recommendation that the service provides a pathway for all caregivers to complete further education and gain a recognised qualification in aged care. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incidents forms from March 2015 was reviewed confirming relatives were advised of incidents when appropriate. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur six monthly and the nurse manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English the interpreter services are made available. All residents were English speaking on the days of the audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kensington House is governed by a shared trust board that oversees Kensington House and two other facilities. The service provides care for up to 32 residents at rest home level care. On the day of the audit, there were 30 residents (one of which was on respite care and one other on an orthopaedic contract).  There is a physiotherapy service available as required. Residents can retain their own general practitioner (GP) on admission and there are two GPs with a number of residents. The service has a mission statement and philosophy. There is an overall business plan and risk management plan and a documented purpose, values, and direction. Kensington House has developed annual quality goals. Progress towards goals is reported through the six weekly quality/staff meeting.  The service is managed by an experienced nurse manager (registered nurse) who has been in the role for 14 years. The nurse manager reports weekly to the village manager who reports to the general manager of operations and the board on a variety of management issues. The current strategic plan and quality and risk management plans have been implemented. The nurse manager is supported by three other registered nurses, one enrolled nurse and care staff. The nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The registered nurse who works during the day and has been at the service for 16 years provides cover during a temporary absence of the nurse manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality manual and the business, quality, risk and management planning procedure describe the Kensington House’s quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality improvement/staff meeting, and the various facility meetings. Monthly and annual reviews have been completed for all areas of service.  Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and caregivers confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 has been completed and there is a schedule for 2015 being implemented. Areas of non-compliance identified at audits have been actioned for improvement.  The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. Staff sign that they have read updates to policies. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The Death/Tangihanga policy and procedure outlines immediate action to be taken upon a consumer’s death. Falls prevention strategies are implemented for individual residents.  Residents’ are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. |
| 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. | PA Low | Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications; however relevant authorities were not notified within required time frame of an outbreak in February 2015. A sample of resident related incident reports for December 2014 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data against previous internal audits. |
| 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 recruitment and staff selection process requires that relevant checks have been completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (one nurse manager, two registered nurses, two caregivers and one laundry/caregiver) and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 27 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Caregivers are orientated by senior staff through the ‘buddy system’. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually and an in-service schedule is being implemented for 2015. Three caregivers have completed an aged care education programme. There is a training programme in place that offers six weekly in-service educations for staff. Attendance records reviewed indicate that these are well attended and cover aspects of care and service delivery related to the rest home level of care. Caregivers are encouraged to attend DHB and aged care external study days. The nurse manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Kensington House has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The actual staffing level is determined according to need both within the rest home also with provision to provide some level of cover if required for the large retirement village complex next to the rest home. For the 32 residents there is a registered nurse on duty each afternoon and the nurse manager is on duty with hands on clinical care for three mornings a week and completes office work for the other two days a week. There is a registered nurse and enrolled nurse rostered on duty to cover the nurse manager’s offices days. The nurse manager is on call 24 hours/seven days a week with designated registered nurses if required.  Staff turnover is also noted to be low. There is always a staff member on duty with current first aid training and current medication competency. |
| 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. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team, and an initial nursing assessment is completed on admission. The service has specific information available for residents/families at entry and it includes associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligns with the ARC contract and exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer /discharge/exit procedures included a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation were forwarded with the resident. |
| 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 Moderate | The service uses individualised medication blister packs which are checked in on delivery. A registered nurse was observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Resident photos were on all 12 medication charts reviewed. Six of twelve medication charts had documented allergies on the medication charts. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted.  There is a self-medicating resident’s policy and procedures in place with one resident currently self-administering. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Nine of twelve medication charts had documented indication for use of, as required medication (PRN), by the GP. Each time prior to administration PRN medication is reviewed by a registered nurse. Some residents choose to retain the services of their own GPs, some of which will not visit Kensington House. Families or staff often has to escort the resident to their GP three monthly review visits. Nine of twelve medication charts had documented GP three monthly reviews on the medication charts. At the time of audit there were four faxed medication charts in use and it suggested that the amendments are transferred onto the original medication chart as soon as is possible by the GP. Three of twelve signing sheets had signing gaps on administration and one medication was administered but was not prescribed by the GP. |
| 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 main meals at Kensington House prepared and cooked at the main kitchen and the breakfasts prepared in the care centre kitchen. Meals are prepared in a well-appointed kitchen adjacent to the Village Restaurant and transported to the care centre kitchen/dining room using hot boxes. There is a four weekly winter and summer menu which had been reviewed by a dietitian. Kitchen staff are trained in safe food handling, safe chemical handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian or GP. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| 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 reason for declining service entry to residents to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family and the appropriate referrer. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents are admitted with a care needs level assessment completed by the needs assessment and service co-ordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. Assessments are reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Resident files reviewed included all required documentation. The long-term care plan of five of the six resident files reviewed records the resident’s problem/need, objectives, interventions and evaluation for identified issues. The service has a specific acute health needs care plan that included short-term cares. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident. |
| 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 current. In five of the six resident files interventions reflect the assessments conducted and the identified requirements of the residents (# link 1.3.5.2.). Interviews with staff (nurse manager, registered nurses and caregivers) and relatives confirmed involvement of families in the care planning process. Dressing supplies were available and a treatment room was stocked for use. Continence products were available and resident files included a urinary continence assessment. Wound assessment and wound management plans were in place for seven residents. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities staff provide an activities programme over five days each week. There are two activity co-ordinators who work two days each. One day volunteers help out from the village. The programme is planned weekly and residents received a personal copy of planned monthly activities. Activities planned for the day were displayed on notice boards around the facility. An activity plan was developed for each individual resident. Residents are encouraged to join in activities that were appropriate and meaningful. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provide a forum for feedback relating to activities. General feedback from three out of five residents and three out of four family members interviewed stated satisfaction with most of the activities programme, the others stating it was not appropriate for them. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations reviewed were completed and related to each aspect of the care plan and recorded the goals and interventions achieved. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Short-term care plans were in use. Care plans reviewed were evaluated within the required time frames. |
| 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 | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family are involved, as appropriate, when referral to another service occurs. |
| 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 | All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the 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 in Kensington House included a toilet ensuite. There are some double sized rooms for residents. All residents share communal showers. There were sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable and include large vacant/in-use signs. |
| 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 | The resident rooms are spacious enough to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for rest home residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised. |
| 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 a large lounge and separate dining room, and a smaller lounge/sun room area at the end of a wing. The dining room is spacious and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in the main lounge. |
| 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 is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. There are secure cleaners cupboard with cleaners trolleys. Staff have attended infection control and safe chemical handling education and there is appropriate protective clothing available. Manufacturer’s data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire and emergency procedures manual. The fire evacuation scheme is approved. All staff members hold a first aid certificate. Fire safety training has been provided. A call bell light over each door and a digital panel in each corridor alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources are available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks have been conducted each night by staff. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms including have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| 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 | Kensington House has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and is linked into the incident reporting system. A registered nurse is the designated infection control nurse with support from the nurse manager. The IC nurse completes a monthly and annual report which is reported at the six weekly quality/staff meeting. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. 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 | There are adequate resources to implement the infection control programme at Kensington House. The infection control (IC) nurse has maintained her practice by attending infection control training and updates. One of the other registered nurses has also attended infection control updates. The infection control team is representative of the facility. External resources and support are available when required. 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 | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control nurse with support from the nurse manager. All infection control training has been documented and a record of attendance has been maintained. 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 are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014/15. |
| 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 and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Resident infection registers are completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly facility infection summary and staff are informed. The data has been monitored and evaluated monthly and annually and reported at the quality/staff meeting.  An outbreak in February 2015 was appropriately managed, with notification to relevant authorities however relevant authorities were not notified as recommend by public health when there are two cases of diarrhoea and vomiting within a twenty four hour period (# link 1.2.4.2). The outbreak started 1 February 2015 and ended 10 February 2015. Eight residents were affected. The service contacted the district health board on 19 February 2015. The service completed appropriate documentation throughout the outbreak and completed a final report. Staff were kept fully informed and relatives were notified. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The policy around restraint and enablers is applicable to the type and size of the service (rest home). The service has a policy of non-restraint and there are no enablers or restraints in use on the day of the audit. Restraint minimisation is overseen by a restraint coordinator who is the nurse manager. There is a restraint minimisation approval group that includes the GP who meet annually. The policies and procedures are comprehensive, including definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. Staff have had training around challenging behaviours, restraint and enablers.  Three caregivers interviewed, the nurse manager and the registered nurse interviewed confirm knowledge of restraint, enablers and management of challenging behaviours. |

# 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 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | Discussions with the nurse manager and registered nurses confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications | The service had a gastroenteritis outbreak in February 2015. Eight residents were affected over a 10 day period (1-10 February). Relevant authorities were not notified until 19 February 2015. | Ensure that relevant authorities are notified of any outbreaks within the required time frame.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | There are clear policies and procedures around safe administering, documentation and prescribing resident medications. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted. | 1) Three of the twelve medication charts reviewed did not include documented evidence of a three monthly GP review. 2) Three resident medication charts with, ‘as required’ medication (PRN) prescribed did not include indication for use. 3) Six medication charts did not document allergies or ‘nil known’. 4) Three resident regular medications not signed for on administering. 5) One medication administered and signed for but was not prescribed. | 1) Ensure all GP three monthly reviews are documented on the medication chart. 2) Ensure all PRN medication had documented indication for use. 3) Ensure all allergies are documented on the medication chart. 4) All prescribed topical medications should be signed for on administration. 5) Only prescribed medications should be administered.  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 | There are policies and procedures around the completing of detailed care plans, which reflect the residents’ needs. | One resident long-term care plan, identified as a high falls risk, did not include sufficient interventions for effective reduction, or prevention of falls and did not reflect the nursing assessments. | To ensure that long-term care plans have detailed interventions in place that reflect the needs of each resident.  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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End of the report.