B.J.M.H.Enterprises Limited - Killarney Rest Home

Introduction

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

The audit has been conducted by Health 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.

The specifics of this audit included:

Legal entity:	B.J.M.H.Enterprises Limited
Premises audited:	Killarney Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 February 2017 End date: 16 February 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: 22

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Killarney Rest Home provides rest home and dementia level of care for up to 22 residents. On the day of the audit there were 22 residents. The service is managed by an owner/manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant health and disability standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed five of the six shortfalls from their previous audit around open disclosure, accident/incidents, staff orientation, risk assessment reviews, and training requirements for the infection control coordinator. Improvements continue to be required around staff training in the dementia unit.

This surveillance audit identified a further improvement required around the food services.

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.

Families interviewed reported that they are kept informed. A system for managing complaints is in place. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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 service is owned by an owner/manager who is supported by a clinical manager/registered nurse. Services are planned, coordinated and are appropriate to the needs of the residents. Quality and risk management processes are established and implemented. Quality goals are documented and regularly reviewed. A risk management programme is in place, which includes incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements.

An orientation programme is in place for new staff. A staff education and training programme is being implemented. Registered nursing cover is available either on-site four days a week, or on-call twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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.

The clinical nurse manager is responsible for each stage of service provision. The clinical manager assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The diversional therapists provide an activities programme for the residents that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Staff responsible for administration of medicines complete education and medication competencies.

All meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents, family/whānau interviewed responded favourably to the food that was provided.

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.

A current building warrant of fitness is posted in a visible location.

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.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. One restraint and no enablers were in use.

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.

The infection control surveillance programme is appropriate to the size and complexity of the service. 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	15	0	2	0	0	0
Criteria	0	37	0	2	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.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. The complaints process is linked to advocacy services. A record of complaints received is maintained using a complaints register. Five complaints were received in 2016 (one written and four verbal). Timeframes for responding to complaints meet requirements set forth by the Health and Disability Commissioner (HDC). All five complaints reviewed were documented as resolved. Complaints received are linked to the quality and risk management system. Complaints received are discussed in staff meetings (evidenced in the monthly staff meeting minutes). Discussions with five rest home level residents and families confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed (two healthcare assistants [one dementia, one rest home] one clinical manager/RN, one activities coordinator) understood about open disclosure and providing appropriate information and resource material when required. Four family members (two dementia, two rest home) interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Twenty accident/incident forms

conducive to effective communication.		reviewed reflected documented evidence of families being informed following an adverse event. This is an improvement from the previous audit. An interpreter service is available and accessible if required through the district health board. Families and staff are utilised in the first instance.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Killarney Rest Home is privately owned and operated. The owner/manager purchased the facility in September 2014. The service provides care for up to 22 residents at rest home and dementia levels of care. On the day of the surveillance audit the facility was full with two residents on the waiting list. There were thirteen dementia level residents and nine rest home level residents. The service is managed by the owner/manager who has previously owned rest homes and receives support from a clinical manager/registered nurse and an external consultant who visits the facility one day per month. The business plan and annual goals indicate that the owner/manager regularly reflects on achievements towards meeting these goals. A comprehensive year-end summary was documented for 2016 outlining both achievements and areas for improvements. The owner/manager has completed at least eight hours of professional development related to management of an aged care facility.
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	A quality and risk management system is established that is understood by staff as confirmed during interviews with the manager and staff (two healthcare assistants, one clinical manager/RN, one diversional therapist, one cook). Policies and procedures align with current good practice and meet legislative requirements. Policies have been updated to reflect processes around InterRAI and pressure injuries. They are regularly reviewed as per the document review schedule. New policies and updates to existing policies are discussed in staff meetings as evidenced in the monthly staff meeting minutes. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected and analysed for a range of adverse event data. Results are shared with staff in staff meetings. Where improvements are identified, corrective actions are documented and are signed off when completed. Examples of quality initiatives for 2016 included the implementation of an electronic medication system (Medimap), the purchase of equipment (hoist, hospital beds, a medication trolley, wheelchairs) and an upgrade to the outdoor areas. A risk management plan is in place. Health and safety policies have been reviewed since the new legislation has come into effect. A health and safety officer has been appointed but was not available on the day of the

		audit. Staff receive health and safety training, which begins during their induction to the service. All staff are involved in health and safety, which is a regular topic in the monthly staff meetings. Actual and potential risks are documented on the hazard register, which identifies risks and documents actions to eliminate or minimise the risks. Falls management strategies include bed sensors and the development of specific falls management plans to meet the needs of each resident who is at risk of falling.
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 incident reporting policy that includes definitions and outlines responsibilities. Incident/accident data is linked to the organisation's quality and risk management programme. Twenty accident/incident forms were reviewed (two pressure injuries, three skin tears, four challenging behaviours, eleven falls). Neurologic observations were conducted for suspected head injuries. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. This is an improvement from the previous audit. The owner/manager is aware of her responsibility to notify relevant authorities in relation to essential notifications with an example provided following an infectious outbreak in 2016.
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.	PA Low	Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one RN, four healthcare assistants – HCAs). Signed employment contracts are held in each file. The owner/manager completes reference checks before employing new staff. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed annually for medication management. Staff interviewed stated that they believed new staff were adequately orientated to the service. All five staff files contained evidence of a completed orientation programme. This is an improvement from the previous audit. A register of current practising certificates for all health professionals is maintained. There is an annual education schedule that is being implemented. Staff training reflects a minimum of eight hours of training per care staff and covers all mandatory training topics. This is an improvement from the previous audit. The clinical manager has completed InterRAI training. Three staff who have worked in the dementia unit for over one year have not completed the required dementia standards.

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 staffing policy aligns with contractual requirements. The own/manager works Monday - Friday. She is supported by a clinical manager who is rostered four days a week and is on call when not on site. Staffing hours are flexible to meet the level of acuity of the residents. A minimum of one HCA is scheduled on each shift for each area (rest home and dementia) with an additional HCA scheduled on a short shift in the dementia unit for the am and pm. A diversional therapist is employed four days a week. Interviews with staff, residents and families confirmed staffing overall was satisfactory.
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	The service had implemented and electronic medication management system three days prior to audit. Ten medication charts were reviewed (four rest home and six dementia). There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The clinical staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were three rest home residents self-medicating on the day of audit. All the necessary self-medication assessments and consents had been completed. The medication fridge temperatures are recorded regularly and these are within acceptable ranges. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.
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.	PA Low	All meals at Killarney are prepared and cooked on site. There is a three weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met. Nutritious snacks are available 24 hours a day for all residents. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Food that was stored in the fridge had not been dated or labelled. Flies were observed in the kitchen and one bench was worn with the Formica benchtop chipped.

		Staff working in the kitchen have completed training in food safety and hygiene and chemical safety.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the clinical manager initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. In the residents' files reviewed, short-term care plans were commenced with a change in heath condition and linked to the long-term care plan. Long-term care plans were reviewed six monthly. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. The clinical manager was able to describe access for wound and continence specialist input as required.
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	A diversional therapist works 32 hours per week and coordinates and delivers the programme for both service levels. A group programme is delivered in the dementia lounge for both service levels. The rest home residents report the group programme meets their needs and participation is voluntary. The activities programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes craft, van outings, church services, games, gardening and happy hours. Two residents attend woodwork groups in the local community. On the day of audit residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities. There was evidence of documented 24-hour activity plans for residents in the dementia unit. The diversional therapist is responsible for the resident's individual recreational and lifestyle plans which are developed within the first three weeks of admission. The resident/family/whānau, as appropriate, are involved in the development of the activity plan. Resident files reviewed identified that the individual activity plan is reviewed 6 monthly. Activities are planned that are appropriate to the functional capabilities of residents. Residents can provide feedback and suggestions for activities at the resident meetings and annual resident satisfaction survey. Residents and families interviewed report satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service	FA	In the files sampled, initial care plans were evaluated by the clinical manager within three weeks of admission. The long-term care plans were evaluated at least six monthly or earlier if there is a change in health condition. There was at least a three monthly review by the GP. All changes in health status were documented and

delivery plans are evaluated in a comprehensive and timely manner.		followed up. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location (expiry 27 August 2017).
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 completed Infection control training in the past 12 months. This is an improvement from the previous audit.
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	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. There has been one outbreak since the previous audit and this was appropriately managed and reported. Systems are in place and are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is	FA	There are policies around restraint, enablers and the management of challenging behaviours. No residents were using an enabler and one resident (dementia level) was using bedrails as a restraint. Risks were identified and the restraint was being used in a safe and appropriate manner. The clinical manager is the restraint coordinator. Restraint minimisation is a regular agenda item at staff

actively minimised.		meetings. Staff receive training around restraint minimisation and safe practice.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	A comprehensive staff training programme is in place which includes both internal and external invited speakers. Attendance rates are 70% or higher. If staff cannot attend, they are given a handout and questionnaire to complete. Three HCAs who have been employed to work in the dementia unit for over one year have not completed the required dementia standards.	Three of ten HCAs who have worked in the dementia unit for over one year are enrolled but have not completed the required dementia standards.	Ensure all HCAs who have worked in the dementia unit for over one year have completed the required dementia standards. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	All food is cooked on site and most ingredients are sourced fresh by the owner/manager. Food is stored correctly in the pantry and dry goods areas. Freezer and fridge temperatures are recorded. End cooked food temperatures are recorded daily. Not all food stored in the fridge had been labelled and dated. The kitchen has two external windows that are used for	i) There is inadequate fly control in the kitchen. ii) The Formica on one bench top is worn and the edges have exposed raw wood. iii) Not all food stored in	i) Ensure that flies are kept out of the kitchen. ii) Ensure all food preparation surfaces have no exposed raw timber.

		ventilation. These windows are frequently left open to create an air flow. These windows do not have fly screens on them. The automatic atomised pest control canister in the kitchen was empty. Flies were observed in the kitchen on the day of audit. One area of bench top in the kitchen is well worn and the top surface layer has worn away. The edges of the bench top are chipped, exposing raw timber.	the kitchen fridge was dated or labelled.	iii) Ensure that all food stored in the fridge is dated and labelled. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.