

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

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](#).

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: 14 June 2018 End date: 14 June 2018

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 care for up to 22 residents. On the day of audit there were 22 residents.

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

The management team includes the director/manager, assistant manager and the clinical manager and they are responsible for the overall management of the facility. Service delivery is monitored.

There are no improvements required.

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.
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Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Management and staff communicate in an open manner and residents and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

The rights of residents or their legal representatives to make a consumer complaint is understood, respected and upheld. An up-to-date complaints register is maintained. Consents are documented by residents or family and advance directives are documented by residents identified as being competent to complete these.

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.		Standards applicable to this service fully attained.
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There is an annual business plan, quality plan and a risk management plan in place. The plans define the scope, direction and objectives of the service and the monitoring and reporting processes.

There is an established quality and risk management system in place. There are a range of policies, associated procedures, and forms in use to guide practice. Quality outcomes data are collected and analysed to improve service delivery. An internal audit schedule is in place. Adverse events when documented, are reported to management and external agencies.

The human resource management system is in place with policies to guide practice. There is an annual training plan in place that includes mandatory training. Health care assistants' complete dementia training.

There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home hospital and the dementia unit. An appropriate number of skilled and experienced staff are allocated each shift.

Resident information is stored securely.

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.		Standards applicable to this service fully attained.
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Entry to the service is managed primarily by the owner/manager. There is comprehensive service information available. The registered nurse completes initial assessments. Care plans and evaluations are completed by the registered nurse within the required timeframes. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed, confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. The general practitioner or nurse practitioner reviewed residents at least three monthly or more frequently if needed. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

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.
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Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are sufficient lounges and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning staff provide appropriate services. Staff have planned and implemented strategies for emergency management.

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.
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The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. Policies and procedures comply with the standard for restraint minimisation and safe practice. Assessment, documentation and monitoring of care and reviews are recorded and implemented. Restraint risks are identified. Staff members receive annual training regarding restraint use.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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 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. 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	45	0	0	0	0	0
Criteria	0	93	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Policies and procedures are in place to ensure consumer rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training schedule.</p> <p>Staff interviewed (including the director/manager, the assistant manager, the clinical manager, the diversional therapist, three caregivers, and the cook), were all able to articulate knowledge of the Health and Disability Commissioner’s Health and Disability Services Consumers’ Rights (the Code) and how to apply this as part of their everyday practice. Staff interviewed confirmed they receive ongoing education on the Code.</p> <p>Visual observations during the audit and the review of five resident records (which included two records for residents at rest home level care and three dementia unit resident records) and other documentation indicate that staff are respectful of residents and incorporate the principals of the Code into their practice. The service provides information on the Code to families and residents on admission.</p> <p>Residents (three rest home) interviewed and family (three dementia unit; one rest home) interviewed stated that they receive services as per the Code.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>FA</p>	<p>There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. There is a culture in the service that was observed during the audit that is about choice and involving the resident in giving consent to activities of daily living. Staff interviewed demonstrated an understanding of informed consent processes.</p> <p>Residents and relatives confirmed that they discuss the principles of consent with relatives and residents on entry to the service with consent for service and confidentiality of information documented on admission. All resident files reviewed included signed consent forms completed on the day of admission.</p> <p>All residents have the choice to make an advanced directive if they are deemed competent by the general practitioner or nurse practitioner. In records reviewed, all competent residents have a documented advanced directive. The resident signs these. The general practitioner or nurse practitioner has made a decision for some residents as not for resuscitation, with this noted as being a clinical medical decision.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There are policies in place regarding advocacy and/or support services. Advocates can also be accessed through the Nationwide Health and Disability Advocacy Service if required. The Nationwide Health and Disability Advocacy Service brochure is provided to the resident and their family/whānau on admission. These brochures are also displayed in the facility. Education on advocacy is provided to staff during orientation and in the ongoing in-service programme.</p> <p>Residents and relatives interviewed, confirmed they are aware that advocacy services are available should they be needed. An advocate was asked to support a resident and the report written did not identify any actions for the service to follow-up with.</p> <p>An independent advocate visits the service and is available for residents and/or family to contact. The advocate is also invited to the three-monthly resident/family meetings.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents have open access to visitors of their choice. There is a visitors' policy and guidelines available to ensure resident safety and well-being is not compromised by visitors to the service. Access to community support/interest groups is facilitated for residents as appropriate with some residents observed to interact in the community on the day of audit. The activities staff are available to take residents on community visits and staff are available to take people to appointments if family are not able to provide transport.</p> <p>Residents interviewed, confirmed they can have access to visitors of their choice at any time and</p>

		are supported to access services within the community.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints management policy and procedure is documented, and follows Right 10 of the Code. The complaints policy and procedure is explained by the staff to residents and relatives as part of the admission process.</p> <p>There are complaint forms available at the main entrance to the building. A book in the cupboard allows staff to document any minor complaints that are resolved at the time the concerns are identified. This allows for the director/manager or assistant manager to monitor minor complaints to ensure that a pattern does not emerge.</p> <p>Two minor complaints were documented on the register in 2018. The director/manager and assistant manager describe these as being taken seriously so that they do not escalate into major complaints. Both showed evidence of information provided to the complainant and of these resolved in a timely manner.</p> <p>An up-to-date consumer complaints register is maintained with documentation including the name of the complainant; date complaint received, acknowledged, actioned, closed; date when advocacy was offered and commenced and outcome/resolution.</p> <p>Staff, residents, and families interviewed have a good understanding of the complaints process.</p> <p>The director/manager and assistant manager confirmed that there are no complaints from external authorities.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service are displayed in the facility and included in the admission information pack. The Code and other rights and information in the information pack are discussed with residents and relatives on admission.</p> <p>Residents and relatives interviewed confirmed that information around the Code, advocacy services and residents' rights are explained on admission.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect</p>	FA	<p>There are a range of policies and procedures in place to ensure residents are treated with respect. Staff endeavour to maximise residents' independence by encouraging residents to actively engage in cares and to continue to access the community as long as possible. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family</p>

<p>and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>interviewed. Residents are referred to by their preferred name as observed on the day of audit.</p> <p>Policies and procedures on abuse and neglect were explained by staff interviewed with a description of how they would escalate any concerns if these were suspected. Staff, family and the nurse practitioner interviewed, confirmed that there was no evidence of abuse or neglect.</p> <p>Residents and relatives interviewed stated that staff have regard for the dignity, privacy, and independence of residents. Any specific cultural, religious, social, and/or ethnic needs or wishes are identified through discussion with residents and/or family (as described by residents and family interviewed) and documented through the assessment and care planning process.</p> <p>There are quiet, low stimulus areas that provide privacy for residents in the dementia unit and opportunities during the day for residents in the dementia unit and in the rest home to undertake activities together with appropriate supervision.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care provision for Māori residents. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection, participation, and equality.</p> <p>Staff interviewed confirmed an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through the annual training programme.</p> <p>There are currently four residents who identify as Māori. There are staff who can speak te reo Māori and any cultural needs are reflected in their assessment and care planning documents. Staff interviewed could describe providing food that Māori enjoy and supporting Māori residents to maintain links with family/whānau and the wider community.</p> <p>Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes, including input from family/whānau as appropriate, for residents who identify as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect</p>	<p>FA</p>	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan.</p> <p>Staff interviewed confirmed their understanding of cultural safety in relation to care.</p>

<p>their ethnic, cultural, spiritual values, and beliefs.</p>		<p>Residents and family members (on behalf of residents in the dementia unit) interviewed, confirmed that values and beliefs are respected by staff.</p> <p>Two Pacifica residents had cultural needs reflected in their assessment and care planning documents and staff could describe specific cultural norms for these residents. The management team encourages external people from the community to come in to support the residents and to share their culture with staff and residents. Staff are also learning to speak Pacifica words and were observed to use these on the day of audit.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions.</p> <p>Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives interviewed reported that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Policies, evidence-based guidelines, treatment protocols, reference material and resources are available and utilised by staff. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice. Management and staff have access to, and demonstrate knowledge of, relevant legislation and approved service standards.</p> <p>The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery. Demonstrated competencies are recorded. Staff interviewed confirmed that the facility provides a resourceful, learning, and supportive environment. Staff stated that both the general practitioner and nurse practitioner who visit the service provide them with information and support whenever required. A review of resident files confirms that staff contact specialists and the general practitioner and/or nurse practitioner when required.</p> <p>Staff, residents, and family can identify improvements to the facility and to service delivery that have occurred in the past year.</p> <p>Residents and family members interviewed confirmed they are very happy and satisfied with the care provided to their relatives.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>The service provider has policies covering communication. Staff have access to interpreters as</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>required.</p> <p>Residents and family confirmed that the management team has an open-door policy and they all stated that they talk about any concerns with these resolved in a timely manner. Information is provided in a manner that the resident can understand. Resident meetings are conducted and provide an opportunity for residents and family members who choose to attend to discuss any concerns or positive changes in the service. The incident and accident forms include an area to document if the relatives have been contacted. Open disclosure is practised and documented when family are contacted.</p> <p>Residents and relatives interviewed confirmed that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirmed that they are advised if there is a change in their family member's health status. The nurse practitioner interviewed reported satisfaction with communication by staff.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>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 audit there was a full occupancy with thirteen residents requiring dementia level care including one under 65 years on a mental health contract and 2x residents on a compulsory treatment order and nine residents requiring rest home level care.</p> <p>The owner/manager provides leadership and operational management along with a hands-on role in the service. Previously they owned another rest home for seven years. The director/manager is supported by an assistant manager who also worked at the previous rest home for seven years. The assistant manager has been in this role for four years, has previous experience as a caregiver in a rest home and dementia unit and provides 20 hours a week support. There is a clinical manager (registered nurse) who has over 15 years' experience working in aged care; has a post graduate diploma in nursing and has experience as a team leader in a psychogeriatric unit. The director/manager and assistant manager have both completed at least eight hours of professional development related to management of an aged care facility and the clinical manager has completed at least eight hours of training relevant to the role.</p> <p>The business plan and annual goals indicate that the director/manager regularly reflects on achievements towards meeting these goals. A comprehensive year-end summary was documented for 2017, outlining both achievements and areas for improvements with the review completed by the director/manager and an external consultant. The purpose, values, priorities, and goals are documented in the annual business plan for 2018. The action points are signed off when completed and as per timeframes documented.</p>

<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>The assistant manager provides cover for the director/manager during the temporary absence of the director/manager. The clinical manager is available and experienced to also provide input into the operational management of the service if required. If the clinical manager is unable to perform the role for an extended period, then a registered nurse is appointed to provide clinical oversight.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality and risk management programme identifies objectives for the service. Activities within the programme are closely linked with health and safety, adverse event reporting, the infection prevention and control programme, restraint minimisation, and the resident complaints process. Quality related data and outcomes are collated, analysed and shared with staff at regular staff meetings. Goals documented in the quality plan include interventions with these reviewed as part of the ongoing quality review process.</p> <p>Policies are reviewed two yearly or as required, as defined by policy. The service uses an external quality and risk management consultant to provide advice on policies, procedures, and forms. Policies sighted reflect current good practice, legislation, and compliance requirements. All documents sampled are controlled, and obsolete documents removed from circulation. Policies and procedures and the internal audit schedule include reference to interRAI and care planning processes.</p> <p>Internal audits are planned and implemented as per the audit schedule. Corrective actions identified as part of the internal audit programme, are discussed at both management and staff meetings with evidence of resolution of issues in a timely manner. Staff sign the staff meeting minutes to indicate that they have attended or read the minutes if unable to attend. The external consultant is invited to attend the monthly management meetings with the management team, including the director/manager, assistant manager, and clinical manager in attendance. Data is analysed, and trends are discussed at both meetings.</p> <p>Satisfaction surveys are conducted with the last completed in May 2018. Eleven respondents confirmed a high level of satisfaction with the service. Family and residents also have input into the service through the six-monthly review of care plans, with this stated by the director/manager and assistant manager as indicating again a high level of satisfaction with the service.</p> <p>There is a risk management plan documented. The risk register is maintained by the director/manager and the assistant manager. Health and safety requirements are being met, including hazard identification. Health and safety systems have been reviewed since the</p>

		introduction of the Health and Safety at Work Act 2015. The clinical manager is identified as the health and safety representative and they can describe their role. Staff interviewed confirmed knowledge of the policy and stated that they are all responsible for health and safety including reporting of any issues as these arise.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). Twelve incident forms were reviewed. The review confirmed that incidents and accidents were being reported and managed appropriately according to the incident itself. Any unwitnessed falls or where a head injury was identified or suspected, included completion of neurological observations for a sustained period of time. The clinical manager signs-off all incidents with actions documented if there was a need to review practice.</p> <p>The incident forms completed showed evidence of immediate responses, investigations and remedial actions being implemented as required. This included reporting to family members and informing the general practitioner or nurse practitioner as required.</p> <p>Monthly statistics on all documented adverse events are collated, analysed and reported at the staff and management meetings. Trends are reviewed with changes to service delivery if relevant.</p> <p>The director/manager, assistant manager and clinical manager understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. No events have been externally reported since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There is an established system in place for human resource management. Employment records were reviewed for the assistant manager, cook and care staff. All records in the sample contained an employment agreement and a position description. The director/manager states that criminal vetting is not completed, as staff are employed after recommendation from others in the industry. If staff are not known to the service, then reference checking is completed, with this sighted in staff records for new staff.</p> <p>All staff requiring an annual practicing certificate have a copy of this on file. This includes confirmation of an annual practicing certificate for external health professionals involved in the care and support of residents, including the general practitioner, nurse practitioner, pharmacists, dietitian, and podiatrist.</p> <p>All staff receive an orientation and participate in ongoing training. A two-yearly training plan is documented and implemented. Staffing is stable, and staff interviewed were knowledgeable around their role. Staff who cannot attend training review the PowerPoint presentation and complete a</p>

		<p>validation questionnaire that is kept in their staff record. Performance appraisals are completed for all staff who have been employed for 12 months or more with each file reviewed including a current appraisal. The clinical manager is interRAI trained.</p> <p>All staff who work in the dementia unit have completed training in dementia as per contractual specifications, apart from one new caregiver who has yet to complete orientation; two including the diversional therapist who are in training and one who has been recently enrolled in the training programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The process for determining provider levels and skill mix is defined in policy and this considers the layout of the facility and levels of care provided.</p> <p>Staffing hours are flexible to meet the level of acuity of the residents. Staff rosters reviewed for the past two months confirm that there is at least one caregiver in each area (dementia and rest home) at all times. An additional caregiver is scheduled on a short shift in the dementia unit in the morning and afternoon. Rosters, staff interviewed and observation on the day of audit, confirmed there are sufficient numbers of staff in each area to meet resident need.</p> <p>There are 17 staff in the service including the three managers who also provide hands-on care as required; diversional therapist (32 hours a week); two cooks and care staff. The clinical manager (registered nurse) is on-site for 32 hours a week and provides on call support.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.</p> <p>Each resident has an individual integrated record.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff can describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner. Resident files are protected from unauthorised access, with these in a secure area when not in use. Sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Entries are legible, dated and signed by the relevant staff member with their designation documented.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The director/manager or assistant manager records all admission enquiries. The clinical manager (registered nurse) screens all potential residents prior to entry, and where appropriate carries out a pre-admission assessment. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the owner manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The service uses an electronic medication management system. Twelve medication charts were reviewed (four rest home and eight dementia). There are policies and procedures in place for safe medicine management that meet legislative requirements. All 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 staff interviewed could describe their role regarding medicine administration. Standing orders are not used. There was one rest home resident self-medicating on the day of audit. The self-medication assessment and consent had been completed.</p> <p>The medication fridge temperatures are recorded regularly, and these are within acceptable ranges. The clinical manager had completed regular audits of the electronic medication system.</p> <p>All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>All meals at Killarney are prepared and cooked on-site. There is a four-weekly seasonal menu, which has recently been reviewed by a dietitian and modifications made as per dietitian</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>recommendations. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Nutritious snacks are available 24 hours a day for all residents.</p> <p>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.</p> <p>Fridge, freezer, and chiller temperatures are monitored daily and recorded weekly. End cooked food temperatures are recorded daily. Food is stored correctly in the fridge, freezers, pantry, and dry goods areas. Staff working in the kitchen have completed training in food safety and hygiene and chemical safety. The service has a registered food plan with Ministry for Primary Industries (MPI).</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents when this occurs, and communicates this decision to potential residents/family/whānau. Those declined entry are referred to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and/or their relative where appropriate. The facility has embedded the interRAI assessment protocols within its current documentation. All residents have interRAI assessments completed. InterRAI initial assessments and assessment summaries are evident in printed format in the files reviewed.</p> <p>Risk assessments have been completed on admission and had been updated at the time of the care plan review in five of five files sampled or when there is a change to a resident's health condition. Care plans reviewed are developed based on these assessments for files sampled.</p>
<p>Standard 1.3.5: Planning</p>	<p>FA</p>	<p>The long-term care plans reviewed describe the support required to meet the resident's goals and</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>needs and identified allied health involvement. Residents and their family/whānau are involved in the care planning and review process in files sampled. Short-term care plans are in use for changes in health status. Staff interviewed reported they find the care plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the clinical manager initiates a review and if required, GP or NP 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.</p> <p>In the residents' files reviewed, short-term care plans have been completed with a change in health condition and linked to the long-term care plan. Long-term care plans are reviewed six monthly.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Caregivers interviewed confirmed there is adequate equipment provided, including continence and wound care supplies. Wound assessment, wound management and evaluation forms are available. The clinical manager could describe access for wound and continence specialist input as required. There were no residents with wounds at the time of audit.</p> <p>Access to specialist advice and support is available through the local DHB. Monitoring forms are in use such as weight, blood pressure and behaviour monitoring charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>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 group and individual activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes woodcraft, pet therapy, canine visits, van outings, church services, games, and happy hours.</p> <p>On the day of audit residents were observed participating in a variety of activities. One-on-one activities are provided by both the DT or caregivers for residents who are unable or choose not to be involved in group activities. There was evidence of activities that may be provided over 24hrs documented within the individual care plans for residents in the dementia unit.</p> <p>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</p>

		<p>that the individual activity plan is reviewed at least six monthly.</p> <p>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.</p> <p>Residents and families interviewed reported satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In the files sampled, 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 or NP. All changes in health status were documented and 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.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical manager initiates referrals to nurse specialists and allied health services using the local DHB referral process. Referrals and options for care are discussed with the family as evidenced in medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were 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 sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	FA	<p>The building has a current building warrant of fitness. The building has two lounge areas with two outdoor garden/patio spaces suitable for residents in both the rest home and dementia unit. The owner/manager is managing the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored</p>

for their purpose.		and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external areas are well maintained. Residents have access to safely designed external areas that have shade. The dementia unit outdoor area is secure. Staff stated they had 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	There is adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Two bedrooms have shared ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed 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 resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. There are two double rooms. 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	The communal areas include a lounge and two dining areas that are accessed by residents from both the rest home and dementia unit, with an additional lounge accessible to rest home residents only, unless residents from the dementia unit are supervised. The communal areas are easily and safely accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe	FA	The facility is cleaned by dedicated cleaning staff five days a week. 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 and relatives interviewed were satisfied with the

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>standard of cleanliness in the facility.</p> <p>All laundry is done on-site by caregivers. Residents and relatives interviewed were satisfied with the laundry service. The May 2018 satisfaction survey also indicated satisfaction of the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The New Zealand Fire Service has approved an evacuation plan in 2002. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place at least six monthly with all staff having completed training. The orientation programme includes emergency and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member on duty with a first aid certificate.</p> <p>All required fire equipment is checked within required timeframes by an external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and a gas BBQ. Emergency lighting is in place.</p> <p>The call bell system is operational with bells in each room. Those tested on the days of audit were working and staff responded to call bells in a prompt manner. Residents interviewed confirm that staff attend promptly when a bell is activated.</p> <p>The dementia unit is secured with key pad entry. A perimeter fence is secure around an external courtyard. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed and doors are locked. The director/manager or person on call can be contacted if staff are concerned, or alternatively the New Zealand police can be contacted if needed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated by either heat pumps or ceiling mounted heaters. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control</p>	<p>FA</p>	<p>Killarney has an established infection control (IC) programme. The infection control programme is</p>

<p>management</p> <p>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.</p>		<p>appropriate for the size, complexity and degree of risk associated with the service. The programme has been reviewed annually. The clinical manager is the designated infection control coordinator. Infection control matters are discussed at all staff meetings. Internal audits have been conducted and education has been provided for staff. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved (there has been no recent outbreaks).</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Killarney. The infection control team includes all staff through the staff meeting. 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.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>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 as required, at least two yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The facility is committed to ongoing education of staff and residents. Education is facilitated by the infection control coordinator (clinical manager) or as delegated to the infection control assistant (an overseas trained nurse with postgraduate diploma in infection prevention and control). The clinical manager has completed external infection control training. All infection control training has been documented and a record of attendance has been maintained. 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 2017.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Staff interviewed, observations, and review of documentation, demonstrated safe use of restraint or enablers. The service has a policy of actively minimising restraint. The service has a documented system in place for restraint and enabler use, including a restraint register. There are no residents using restraint in the rest home or dementia unit and three residents using restraint when in bed. There are no enablers being used in the facility.</p> <p>The restraint coordinator is the clinical manager. An interview with the restraint coordinator confirmed knowledge of restraint and use of enablers. They also described discussion of any potential use of restraint or enablers in meetings held monthly with documentation in minutes confirming this.</p> <p>Staff have at least annual training in management of challenging behaviour. Staff interviewed are able to describe management as per policy with this individualised according to the specific individual resident and strategies documented in care plans.</p>

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there 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.