

# Kena Kena Rest Home Limited - Kena Kena Rest Home

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## 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:** Kena Kena Rest Homes Limited

**Premises audited:** Kena Kena Rest Home

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

**Dates of audit:** Start date: 14 May 2018 End date: 15 May 2018

**Proposed changes to current services (if any):** The service has dropped their residential disability services- physical from their certificate.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 40

# Executive summary of the audit

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## 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
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Kena Kena rest home provides rest home and residential disability physical level care for up to 41 residents. On the day of the audit there were 40 residents.

This certification audit was conducted against 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 residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

Kena Kena rest home is owned and operated by three directors for 21 years. Two of the directors are registered nurses. They own another local rest home. The directors are supported by an operations manager, part-time registered nurse and a long-serving workforce. Residents and family interviewed were very complimentary of the service and care they receive at Kena Kena rest home.

This certification audit identified two areas for improvement around care plans and restraint monitoring.

The service has achieved two continuous ratings around the reduction of falls and the reduction of urinary tract infections.

## 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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Kena Kena rest home management and staff provide care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## 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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The quality and risk management plan and quality and risk policies describe Kena Kena rest homes quality improvement processes. Policies and procedures are maintained by an external quality advisor who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meet current legislative requirements. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an

education programme covering relevant aspects of care and on-line learning and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident, and goal orientated. Care plans were evaluated six monthly. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three-monthly general practitioner review. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the residents assessed needs and abilities and residents advised satisfaction with the activities programme.

The medication systems, processes and practices are in line with the legislation and contractual requirements. Medication charts were reviewed. The general practitioner completed regular and timely medical reviews of residents and medicines. Medication competencies were completed annually for all staff that administered medications.

Residents' food preferences and dietary requirements are identified at admission and all meals cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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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The building holds a current warrant of fitness. The preventative and reactive maintenance programme includes equipment and electrical checks. All resident bedrooms provide single accommodation with wash hand basins except for one room and the nine units which have full ensuite facilities. Residents' bedrooms were personalised and of adequate size. Lounges, dining areas and various other small lounges or seating areas are available for residents to sit. External areas are safe and well maintained. An appropriate call bell system is available and security systems are in place. Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a staff member on duty at all times with a current first aid certificate.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. The restraint coordinator completes consents, assessments and evaluations. An approval group review

restraint/enabler use annually. Staff receive regular education and training on restraint minimisation. There was one restraint and one enabler in use on the day of the audit.

## 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The owner/director/RN nurse manager has responsibility for infection control and collates the monthly infection data. The infection control coordinator has completed on-line infection control training and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

## 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)
<b>Standards</b>	0	48	0	2	0	0	0
<b>Criteria</b>	2	97	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) posters are displayed and brochures are readily available to residents and their families. A policy relating to the Code is implemented and staff interviewed (one registered nurse (RN), six caregivers and one diversional therapist - DT) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through the staff education and training programme.</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>	FA	<p>Written informed consent is gained for general consents and were sighted in the seven resident files sampled. Written consent is also gained for specific procedures such as the influenza vaccine. Resuscitation status had been signed appropriately. Residents interviewed confirm they were given good information to be able to make informed choices.</p> <p>Staff interviewed stated the family are involved with the consent of the resident. Enduring power of attorney (EPOA) documents were sighted on the resident's files reviewed. Discussion with family identify the service actively involves them in decisions that affect their relative's lives.</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>Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Advocacy brochures are displayed at the front entrance. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff completed advocacy training June 2017.</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>The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. The service described how they connect younger people with the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The privacy officer is the nurse manager who leads the investigation of any concerns/complaints in consultation with relevant others. Concerns/complaints/compliments are an agenda topic at the monthly quality assurance meeting as sighted in the meeting minutes. Complaints forms are visible at the main entrance of the facility. There have been no complaints for 2017 and 2018 to date. Residents and families interviewed are aware of the complaints process. A complaint register is maintained.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The owner director/registered nurse manager discusses aspects of the Code with residents and their family on admission. Five residents and six family members interviewed reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy,</p>	<p>FA</p>	<p>The residents' personal belongings are used to personalise their rooms. Caregivers interviewed reported that they knock on bedroom doors prior to entering rooms as evidenced on the day of audit. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit, confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which begins</p>

and independence.		during their induction to the service.
<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>	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. The service has a Māori Health plan in English and Māori, which identifies the importance of whānau/family and links with Māori community. There were two Māori residents on the day of audit who did not identify with Māori culture. Staff receive education on cultural awareness during their induction and as part of the education programme.
<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 their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents' care plans in the seven resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries, including the scope of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	Good practice was evident. The owner/director/RN nurse manager is on-site Monday to Friday and an RN is available on-call. A general practitioner (GP) visits the facility regularly and is available after-hours. Residents and family/whānau interviewed reported that they are very satisfied with the services received. The service has a Careerforce assessor who has supported staff through the levels of Careerforce qualifications. Staff are made aware of any new/reviewed policies/procedures.

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Residents/relatives interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Five incident forms reviewed identified family were notified following a resident incident. The nurse manager and RN confirmed family are kept informed. Family members interviewed confirmed they are notified promptly of any incidents/accidents. Resident meetings are open to family to attend. Relatives meet with the management and RN at least six monthly to review the residents plan of care. Email communication with families including annual newsletters was evident. Families are also kept up-to-date on facility matters and activities through the Facebook page. The service has access to interpreter services as required.</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>Kena Kena rest home is certified to provide rest home and residential disability- physical level care for up to 41 residents. There were 40 permanent residents under the ARC contract including one under the long-term chronic health condition contract and younger person under a residential disability contract.</p> <p>The facility is owned by three directors for 21 years. The directors have purchased another rest home facility (Kapiti) a year ago which is located nearby.</p> <p>One owner/director is the nurse manager for Kena Kena and a second owner/director is the nurse manager for Kapiti and on-site daily for a director/management handover. The third owner/director has responsibility for property and maintenance for both sites. All owner/directors have many years' experience in the aged care industry. They are supported by an operations manager responsible for non-clinical services, human resources and accounts/administrative duties. A part-time RN is employed for three days a week at Kena Kena (RN duties and interRAI) and one day per week at Kapiti for completing interRAI assessments.</p> <p>There is a 2017-2018 business plan that includes the service mission statement "to provide a safe, family style environment for each resident" focusing on "safety, companionship, fun, purpose, respect and dignity". The 2017-2018 strategic business plan includes environmental goals (ongoing refurbishment) and the implementation of an electronic medication system. In the last year, dining room chairs have been recovered, new vinyl in service, purchase of a standing hoist and new wardrobes installed in resident rooms. The owner/directors communicate daily on operational matters and hold an annual directors meeting.</p> <p>The nurse manager has attended at least 8 hours of professional development relating to her role including (but not limited to); a leadership and management day and three Nations falls seminar. The operations manager has a bachelor's degree in business management and human resources.</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 two owner/directors/ nurse managers of each facility provide cover for each other's absence. They also share the on-call requirement.</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 plan and quality and risk policies describe Kena Kena rest home quality improvement processes. Policies and procedures are developed and maintained by an aged care consultant and reviewed regularly to ensure they align with current good practice and meet legislative requirements. Staff are required to read and sign they have read new/reviewed policies.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. A relative survey was completed December 2017 with 88% of responses very satisfied and 19% satisfied. Relatives are informed of outcomes through the annual newsletter and Facebook site. There is an internal audit programme that covers environmental, clinical and non-clinical areas. Corrective actions have been generated and completed for any audit outcomes less than 100%.</p> <p>Data is collected, analysed and compared monthly for a range of adverse event data (for example skin tears, bruising and falls). Corrective actions are documented and implemented where improvements are identified. Information is shared with all staff as confirmed in meeting minutes and during interviews. There are monthly quality assurance meetings with management and representatives from each area. Staff meetings are held at least three monthly. Meetings are combined with both rest homes when guest speakers attend or team building exercises are arranged. Communications books and other service meetings are held as required.</p> <p>A 2018 risk management plan is in place. The owner/director/RN nurse manager is the health and safety coordinator. Staff receive health and safety training, which is initiated during their induction to the service and ongoing through the annual training plan. All staff are involved in health and safety, which is a topic in the monthly quality assurance and staff meetings. There is a current hazard register. Hazard reports are completed and the hazard controls for each area reviewed as required.</p> <p>Falls management strategies and the development of specific falls management plans are in place to meet the needs of each resident who is at risk of falling. The service had reduced falls over the</p>

		last seven months by 47%.
<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 incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. Five accident/incident forms (two skin tears and three falls) were reviewed from March 2018 and evidenced RN assessment and follow-up. Head injury observations are conducted for suspected head injuries. The nurse manager and operations manager reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. There has been one notification to the public health for an influenza A outbreak in June 2017.</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 are human resources policies to support recruitment practices. Six files reviewed (one operations manager, one RN, two caregivers, one diversional therapist and one cook) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Eleven-week appraisals were conducted, then annually thereafter. Performance appraisals were up-to-date. Current practising certificates were sighted for the nurse manager, part-time RN and allied health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Long-serving staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements is implemented and attendance records are maintained. Monthly training and questionnaires are completed for each training session. The service has appointed a qualified DT Careerforce assessor to coordinate and support staff through the formal Careerforce qualifications. Sixteen of 19 caregivers have completed Careerforce qualifications (two with level 2, 11 with level 3 and two with level 4). Staff are also supported to attend external education as offered. Clinical staff complete competencies relevant to their role including medication competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support across the three wings (Peach – 13 beds, Lemon – 8 beds</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>and Pink – 10 beds) and the nine studio rooms (any studio room can be a double). The nurse manager is on-site Monday to Friday. The part-time RN works three days per week. There are six caregivers on the morning shift (two full and four short shifts), four on the afternoon shift (two full and two short shift) and two caregivers on night shift with an on-call person. There is a designated cleaning person. Care staff complete laundry duties.</p> <p>The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.</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>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or RN, including designation.</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>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Admission agreements reviewed align with contractual requirements.</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>	<p>FA</p>	<p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. A record is kept, and a copy of details is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service using the yellow envelope system. The registered nurse verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs, and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided. Medications (blister packs) are checked on delivery against the medication chart and any discrepancies fed</p>

<p>safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>back to the pharmacy. All medications are stored safely in the locked treatment room. Standing orders are not used. There were no self-medicating residents on the day of audit. The medication fridge is monitored daily. All eye drops were dated on opening.</p> <p>Fourteen pharmacy generated medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three monthly. The administration signing sheets reviewed identified medications had been administered as prescribed. Prescribed 'as required' medications include the indication for use. The dose and time given is signed for on the administration signing sheet.</p> <p>Staff were observed administrating medicines safely.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food is prepared and cooked on-site at Kena Kena Rest Home. There are two cooks that cover the seven-day week. Both cooks have completed food safety units. Tea staff are rostered on duty in the afternoons to cover the evening meal. There is a five-weekly rotating menu that has been reviewed by a dietitian. A food safety plan is being developed in association with the NZ aged care association, which has an extension date until 31 May 2018 to submit the plan. The meals are served from the kitchen directly to residents in the adjacent dining room. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated. The meals were well-presented, and residents confirmed that they are provided with alternative meals as per request.</p> <p>Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. A cleaning schedule is maintained. All containers of food stored in the pantry are labelled and dated.</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>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate, if entry was declined.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	<p>FA</p>	<p>The RN or nurse manager complete an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and six</p>



<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>monthly, or earlier due to health changes for long-term residents under the ARCC. A three-monthly nursing assessment is completed before each GP visit. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. The long-term care plans reflect the outcome of the assessments. Additional assessments were sighted in the resident's file including the medical assessment completed by the GP and individual social assessment and plan completed by the diversional therapist.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>An initial plan of care was developed on admission. Residents' long-term care plans reviewed were resident-focused and individualised and developed within three weeks of admission. Care plans reviewed had been evaluated for identified issues, however not all interventions were included in sufficient detail to guide care staff. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Care plans are reviewed six monthly and updated to reflect changes to supports/needs.</p> <p>Short-term care plans were sighted for short-term needs and these were either resolved or if an ongoing problem, transferred to the long-term care plan.</p> <p>There was evidence of allied health care professionals involved in the care of the resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions 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 RN initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the contact with family member record page held within the resident file.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan (includes dressing type and evaluations on change of dressings) were in place for one pressure injury stage one, a chronic ulcer and a skin tear. There is access to a wound nurse specialist and district nurses for advice for wound management.</p> <p>Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and</p>

		challenging behaviours.
<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>	FA	<p>A diversional therapist is employed from 9.00 am to 5.00 pm per day five days a week at Kena Kena to coordinate and implement an activity programme that meets the recreational needs of the residents.</p> <p>Different activities are provided to meet the needs of younger residents. The activity coordinator attends on-site in-service and has ongoing involvement with Careerforce as an assessor. An activity assistant provides support with activities from 9am-5pm Tues-Fri, and 9am-12pm on Saturdays.</p> <p>Activities are meaningful and include (but are not limited to); exercises to music, daily group walks, golf putting, quizzes, board games, pampering sessions and craft. There are visiting churches, library, school students and pet therapy. All festivities and birthdays are celebrated. Outings into the community include the local working man's club, vista club beach outings, chocolate factory visits and other rest homes for games tournaments etc. Residents are supported to attend their own church and other community functions. Younger persons are supported to maintain their community links and are also involved in meaningful activities such as assisting with preparation for theme events. Personal planning/assistance is allocated within the activities programme for all residents and also focusing on the needs of younger people in regard to shopping, individualised activities and interests.</p> <p>A resident activity assessment is completed on admission. The recreation assessments included personal interests, family history, work history and hobbies to ensure resident's participation in the activities. Each resident has an individual activity plan, which is reviewed six monthly as part of the multi-disciplinary review. The service receives feedback on activities through one-on-one feedback, monthly activities evaluations, resident's meetings and surveys.</p> <p>During the on-site visit, activities included residents participating in group sessions, listening to music and one-on-one activities. The weekly programme is documented on a central whiteboard and each resident had their own copy of the programme. Residents and family confirmed they were happy with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<p>Six of seven initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. One resident had not been at Kena Kena for three weeks. Long-term care plans had been evaluated six monthly for five of the seven resident files reviewed. Two residents had not been at the service six months. Written evaluations</p>

timely manner.		identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals. Daily progress notes were completed by the caregivers with regular input by the RN or manager. Progress notes reflected daily response to interventions and treatments.
<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>There are documented policies and procedures in relation to exit, transfer or transition of residents. Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files.</p> <p>The residents and the families are kept informed of the referrals made by the service.</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>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored safely in laundry and housekeeping areas. Personal protective clothing is available for staff and was observed being worn by staff as they were carrying out their duties on the day of audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>One of the three directors is the on-site maintenance person. External contractors are used for plumbing, electrical and other specialist areas. There is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Calibration reports for medical equipment were reviewed along with electrical safety tags on electrical items. Hot water temperatures are monitored monthly and are maintained at a safe temperature. Documentation and observations evidenced a current building warrant of fitness displayed that expires 4 June 2018. The operations manager advised a new one is due to be issued.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to several well maintained outdoor areas. Seating and shade is provided.</p> <p>The RN and care staff interviewed stated they have sufficient equipment including mobility aids,</p>

		wheelchairs and pressure injury resources, and a hoist (for use in the case of falls) to safely deliver the cares as outlined in the residents' care plans. Residents interviewed confirmed they are able to move freely around the facility.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	All bedrooms have hand basins and one room in the peach wing has a full ensuite. The nine studio units have full ensuite facilities. There are communal toilets and showers for those in rooms without ensuites. Communal shower/toilets have privacy locks and a system that indicates if it is vacant or occupied. Residents confirmed staff respect their privacy while attending to their hygiene cares. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All rooms in the peach, pink and lemon wings are single. The nine rooms in the units are large enough to accommodate two people should a couple wish to share. Each resident room has individual furnishings and décor. There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Communal areas within the facility include a dining area, several lounges and a foyer. There are small lounges attached to each wing and a shared dining room and lounge in the studio wing. All furniture is safe and suitable for the residents. Communal areas are easily accessible to residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. Chemicals are stored safely in locked cupboards when not in use. Manufacturer's data safety charts are available. All linen and personal clothing is laundered on-site by care staff. The care staff described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. There are dedicated cleaners to carry out cleaning duties throughout Kena

		Kena. Cleaning trolleys are stored safely when not in use. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.
<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>	FA	<p>Emergency, disaster policies and procedures are documented for the service. There is an evacuation scheme that has been approved by the fire service 10 August 2010. Fire drills occur every six months. The orientation programme and annual education/training programme include fire and security training. A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water (600 litre outdoor tank and emergency water supply underneath the studio apartments) and emergency civil defence supplies which are all checked six monthly. A gas BBQ is available for alternate cooking. There is emergency lighting and the service has a generator.</p> <p>A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell in close proximity. The building is secure after hours with all external doors alarmed and linked to the call bell system. One afternoon shift staff member and the night shift person wear a security pendant that is linked to a local security company. There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid certificate.</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>	FA	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Residents and family interviewed confirmed the facility is maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control 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>	FA	<p>The nurse manager (based at their second facility) has overall responsibility for infection control across the two facilities and the collation of infection events. She is supported by the nurse manager of Kena Kena. The infection control programme for Kena Kena has been reviewed March 2018.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. Staff uptake of the influenza vaccine was 95%. There has been one influenza outbreak June 2017. Regional public health at the DHB had been notified (sighted). Case logs and relevant documentation were completed.</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>	FA	<p>The infection control coordinator has completed an on-line MOH infection control course in February 2018. There is access to infection control expertise within the CCDHB, wound nurse specialist, infection control reference manual and laboratory services. The GP monitors the use of antibiotics.</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>	FA	<p>The infection control policies have been developed by an aged care consultant and reflect best practice. There is a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control.</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>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control and hand hygiene is included in staff orientation and as part of the annual training schedule.</p> <p>Resident education is expected to occur as part of providing daily cares.</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>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly quality assurance meeting with representatives from each service area. Meeting minutes are available to staff who read and sign to declare they have read them. The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed and preventative measures put in place as required. The service has been successful in reducing urinary tract infections below the service clinical indicator.</p>

		Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers that meet the restraint minimisation and safe practice standard. The owner/director/RN nurse manager for Kena Kena is the restraint coordinator. There was one resident with an enabler (wheelchair belt) and one resident with a restraint (bedrail). Staff receive training around restraint minimisation and managing challenging behaviours. Voluntary consent had been given for the use of the enabler.  Training around restraint minimisation, enablers and challenging behaviour has been provided as part of the orientation for all new staff.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibility for the restraint coordinator and for staff are documented in policy. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Staff receive education on restraint minimisation and safe practice. Staff complete a restraint questionnaire.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. The file for the one resident using restraint was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan (link

		1.3.5.2). An internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers. There were gaps in the monitoring forms for the two residents with a restraint and an enabler.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in the one resident file where restraint was in use. Restraint use is discussed at the monthly quality assurance meeting. This was confirmed in the meeting minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed annually, which includes a review of all policies, procedures and processes. There have been no adverse events from the use of restraint for one resident.



## 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)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	The registered nurse is responsible for completing all necessary assessments and then using this information to document the care plan. Restraint assessments and approvals are in place, however the risks associated with the use of restraint were not documented in the care plan. Pain assessments were evidenced for one resident including a short-term care plan related to medication changes, however there were insufficient interventions to guide care staff. The use of analgesia including controlled drugs was documented in the progress notes, however the effectiveness the analgesia was not	<p>(i) There was no pain management plan and no effectiveness of analgesia recorded for one resident.</p> <p>(ii) There were no risks associated with restraint and enabler identified in</p>	<p>(i) Ensure care plans document all interventions for pain management and the effectiveness of analgesia is recorded.</p> <p>(ii) Ensure the risks involved in restraint and</p>

		documented.	the care plans of two residents.	enabler use are documented in the resident's care plan.  90 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	PA Low	There are monitoring forms in place for the one restraint and one enabler. Care plans identify the frequency of monitoring and the cares required during a period of restraint. Monitoring forms were not consistently completed.	Two residents (one enabler and one restraint) monitoring forms were reviewed. There were documentation gaps identified in monitoring forms over several months.	Ensure restraint and enabler monitoring requirements are met as instructed in the care plans.  60 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The service collates adverse events for falls, skin tears, bruises and challenging behaviour. The service identified an increase in falls without injury over the past year and developed an action plan to reduce falls.	Annual and monthly comparisons identified that falls without injury had increased to an average of 6.83 from September 2016 to August 2017. An action plan included an analysis of each incident to identify the cause, medical reviews of medications, purchase of more sensor mats, implementation of intentional rounding of high risk residents and training for staff on falls prevention. The owner/director/RN manager attended a falls prevention seminar by the DHB and provided staff with education. Staff were required to attend education and complete a falls prevention questionnaire (September 2017). From September 2017 to April 2018 there has been a decrease in the number of falls to an average of 3.62. The service has been successful in reducing falls by 47%.
Criterion 3.5.7	CI	In May 2017, the service identified	The service identified an opportunity to reduce the number of UTIs, due to an increase in May 2017. An action plan was developed and communicated to staff that included; caregivers

<p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>an increase in urinary tract infections (UTI) to four from the normal average of one to two infections per month. An action plan was developed and implemented with a reduction in UTIs to one per month.</p>	<p>checking that residents had consumed their morning and afternoon tea fluids, additional fluid rounds, residents prone to UTI were prescribed cranberry capsules, cooks to alert caregivers if residents have not had their fluids with meals when they collect the trays/clear the dining room tables, all medication given with a full glass of water, use of incontinence wipes when changing pads and ongoing training of staff. The UTI rate dropped to zero to one per month from June 2017 to December 2017. An increase in UTIs to four in January was identified due to the unusually hot month. Residents were reminded to consume the fluids offered and staff reminded to continue offering additional fluids in all forms (e.g., ice blocks/jellies). This resulted in a further three consecutive months of one UTI per month. The service has been successful in reducing UTIs below the facility indicator of one to two UTIs per month.</p>
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End of the report.