Residential Management Limited - Terence Kennedy House

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Residential Management Limited
Premises audited:	Terence Kennedy House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 April 2021 End date: 30 April 2021

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: 40

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

Terence Kennedy House provides rest home and hospital level care for up to 45 residents. On the day of the audit there were 40 residents. The service is managed by experienced hospital and clinical managers with support from the General Manager. The residents and relatives interviewed all spoke very positively about the care and support provided.

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

This audit has identified the following shortfalls around implementation of care, and self-administration management.

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.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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.

Services are planned, coordinated and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A documented quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, seven days a week.

The resident files are appropriate to the service type.

Continuum of service delivery

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

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

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

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families report satisfaction with the activities programme. All meals are provided on site. Resident individual preferences, likes and dislikes are known to kitchen staff. There is a dietician review of the menu. Choices are offered.

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.

Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building holds a current warrant of fitness. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Fixtures, fittings, and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. 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 emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. A staff member trained in CPR and first aid is on duty at all times.

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.

Terence Kennedy House has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents using restraint. Six residents were using an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There have been two outbreaks in the previous year, both were appropriately managed.

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	43	0	1	1	0	0
Criteria	0	91	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with the general manager, hospital manager and clinical manager; and staff including four healthcare assistants, two registered nurses (RN), one activities coordinator, the cook, maintenance, one laundry staff and one cleaner confirmed their familiarity with the Code. Interviews with seven residents (one rest home and six hospital) and two hospital families confirmed that services are being provided are in line with the Code. The Code is discussed at resident, staff, and quality meetings. Code of Rights training including advocacy, informed consent, privacy, and prevention of elderly abuse, are part of the mandatory training days that staff undertake which are facilitated twice a year to ensure all staff attend.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	There is an informed consent policy. In all seven files reviewed, (five hospital and two rest home residents), residents had general consent forms signed on file. Care staff were knowledgeable around informed consent. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy.

informed choices and give informed consent.		There was evidence in files reviewed of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files reviewed. Copies of enduring power of attorney (EPOA) were on resident files reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Staff and residents informed they are aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friend's networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of complaints process. There are complaint forms available, and family and residents stated that they knew where to get these from. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaint register. Verbal and written complaints are documented. There have been fifteen complaints in 2020 and two in 2021 year to date. The complaint documentation was reviewed for three complaints. All had documented investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to bring up any concerns. Two complaints were sent to the district health board and to the Health and Disability

		Commission. One has been closed with no actions required by the service.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the managers discuss the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies which align with the requirements of the Privacy Act 2020. Staff were observed respecting resident's privacy and can describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs are met. There is a policy that describes spiritual care. Church services are conducted weekly. All residents interviewed indicated that resident's spiritual needs are being met when required.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There were no residents who identified as Māori on the day of the audit. Discussions with staff confirm that they are aware of the need to respond to cultural differences and described how they would document the care plans for the specific cultural requirements of Māori residents. The managers have links with Hoani Waititi Marae close by in West Auckland and there is a health care assistant who identifies as Maori and who is able to provide guidance when required.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and	FA	The service has established cultural policies aimed at meeting the cultural needs of its residents. All residents interviewed report that they are satisfied that their cultural and individual values are being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident and/or their family/whānau are asked to consult on. Staff have received training on cultural awareness in the past year. One resident is not able to speak English however family provide support for the resident.

beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed report that the staff respect them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least two-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data is collected and discussed. The clinical manager and hospital manager along with the general manager collate and monitor data with all discussed at the relevant meetings. Feedback is provided to staff. Corrective action plans are developed where results do not meet targets. Health professionals are engaged to support a resident when required. A general practitioner visits residents twice per week with on-call medical services available 24/7. In the selection of resident files reviewed, care plans reflected input from physiotherapists, dietitians, and podiatrists. Residents and family interviewed confirmed that they were very satisfied with care provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twenty-one incidents/accident forms were reviewed. The forms included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. There were no residents requiring the use of interpreting services. Managers are aware of how to access interpreting services if required.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Terence Kennedy House is an aged care facility located in West Auckland. There are 45 dual purpose rest home and hospital level beds. On the day of the audit there were 40 residents. There were four rest home level residents, and 36 hospital level residents, including one resident admitted under the long-term service - chronic health care contract, and one resident admitted under an ACC contract. A business plan is in place for 2020 with this reviewed prior to the documentation of the 2021 business plan. The 2021 business plan is being implemented and reviewed. A mission, philosophy and objectives are documented for the service. There are monthly management meetings that include managers from two sites owned by the same company. There are also quality review meetings held two-monthly with managers from both sites joining the meetings. The general manager (GM) has 15 years of management experience in the aged care sector. The GM has qualifications in software development. The hospital manager is supported by the clinical manager who has been in the role for 18 months and has over 25 years' experience in aged care. The hospital manager has been in the role for one year with 10 years' experience in aged care overseas. Managers have received at least eight hours training relevant to their roles in the past year.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The general manager and clinical manager provide cover in the absence of the hospital manager, and if either one is on leave. This was confirmed through interview on the day of audit.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	A quality and risk management programme is in place. Interviews with the managers and staff confirmed an understanding of the quality and risk management systems that is in place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed with recent reviews of the urinary tract infection policy with reference to catheterised residents, the catheter policy with timeframes now included around emptying and changing catheter bags, and other interventions related to catheters. Policies and procedures have been updated to include reference to the

		reviewed Privacy Act. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are expected to sign that they have read the new/revised policies. Quality management systems are in place including internal audits; incident and accident reporting; health and safety reporting; infection control data; and complaints management. Data is being collected monthly and discussed with and communicated to staff. There are a range of meetings to ensure that all staff are knowledgeable and up to date including a monthly meeting that include staff meetings, health and safety and infection control, resident (was two monthly, but timeframes increased to ensure all residents were kept updated around Covid 19), and registered nurse meetings. Corrective actions are documented when issues or shortfalls are identified and there is evidence of resolution of issues in a timely manner. The resident and family satisfaction survey completed last in June 2020 showed that they were very satisfied with services provided. There were no identified areas for improvement. A number of quality improvements have been made since the last audit including the introduction of a computerised documentation system; review of continence, neurological observations, interRAI assessment process and care planning; use of the Lab Tests Portal that has provided quicker access to results; and an integrated comprehensive approach to the Covid 19 pandemic as per Public health and Ministry of Health guidelines and instructions. A Palliative Care – End of Life booklet for families has been developed. The phone system has been updated and a nurse call escalation system put in place. A health and safety programme is in place that meets current legislative requirements. A review of health and safety documentation confirms that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is reviewed monthly with any hazards addressed in a timely manner. Falls prevention strategies include the use of sensor mats and implementing strategies for frequent fallers.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The service collects incident and accident data and enters this information into an electronic register for data collation and analysis. The system provides monthly reports, which are then discussed at the staff meetings. There were 21 resident-related incident forms reviewed with these documented electronically. All incident forms (one choking episode, two skin tears and eighteen unwitnessed falls) identified a timely RN assessment of the resident and corrective actions to minimise resident risk and reoccurrence. Neurological observations were completed for seventeen unwitnessed falls but did not consistently follow protocol (link 1.3.6.1). Families had been contacted for all incidents.

		Staff interviewed could describe the incident reporting process. The clinical manager investigates and signs off on all incident reports. The clinical manager interviewed could describe situations that would require reporting to relevant authorities. There were a number of notifications to the Ministry of Health as per Ministry of Health direction around registered nurse shortages from January 2020 to March 2021 with the clinical manager and hospital manager stepping in to cover some shifts as required. There is now a full complement of nursing staff. There is also one section 31 notification for a pressure injury and for changes in the hospital manager.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources management policies in place. A copy of practising certificates is kept. Seven staff files were reviewed (one clinical manager, one registered nurse, one activities coordinator, one cook, one laundry and two healthcare assistants) and all evidenced that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2020 has been reviewed and a plan for 2021 is being implemented. All care staff have completed training related to clinical care following review of policies e.g. catheter care planning and management of recurrent urinary tract infections (UTIs), training based on BPAC's A Pragmatic Guide to Asymptomatic Bacteriuria and Testing for UTIs in People Aged over 65, indwelling catheters using a case study approach. Competencies are completed as per annual training competencies. Managers and registered nurses are able to attend external training, including sessions provided by the local district health board. Five registered nurses have completed interRAI training with one currently in training. The clinical manager is also interRAI trained. Annual staff appraisals are evident in all staff files reviewed. There are 25 healthcare assistants who have completed the following levels as per CareerForce: 10 level 4, 4 level 3, 2 level 2, and 9 level 0. The managers encourage staff to engage in training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably	FA	The policy includes a staffing rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The hospital and clinical managers are on-site Monday to Friday and on call after hours. The general manager is also on call with the clinical manager at the second site also able to be called if required.

qualified/skilled and/or experienced service providers.		The following staff are rostered: seven healthcare assistants on the morning shift (two long and three on a short shift including one from 8AM-2.30PM, two from 7AM-1PM, and two from 8AM-12PM); six healthcare assistants on the afternoon shift (two long and four on a short shift including three from 4PM-8PM and one from 5PM to 9PM); two healthcare assistants on night shift. Rosters were reviewed for the past three months and showed that extra staff were called in for increased resident requirements and staff were replaced when on leave. The service has a pool of casual staff and has only had to use bureau staff four times since March 2021. There is a team leader (healthcare assistant) on sides A, B, C who allocates staff to a group of residents and who oversees staffing to ensure that there is a mix of new and more experienced staff with each group of residents. Activities staff are rostered on five days per week. There are separate domestic staff that are responsible for cleaning and laundry services. Interviews with staff, residents and family members confirms that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant, registered nurse, or other healthcare professional.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There is an implemented organisational admission policy. All residents have a needs assessment completed prior to entry that identifies the level of care required. The hospital manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. An information pack including all relevant aspects of the service, advocacy and health and disability information is given to residents/families/whānau at entry. All relatives interviewed were familiar with the contents of the pack. The admission agreement provides information on services which are excluded, and examples of how services can be accessed that are not

		included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating on the day of audit, who had been initially assessed as competent to self-administer by the RN and GP, however competence had not been reviewed as per policy. There are standing orders in use which are comprehensively documented, including indications for use, frequency, and maximum doses. These are reviewed three-monthly by the GP. There are no vaccines stored on-site. The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications, have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily. Eye drops viewed in both medication trolleys had been dated once opened. Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	FA	All meals at Terence Kennedy House are prepared and cooked on-site. There is a four-weekly seasonal menu which has been reviewed by a dietitian last in December 2020. Meals are plated in the kitchen and then served in the two dining rooms. End cooked meals and fridge and freezer temperatures are recorded.

service is a component of service delivery.		Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met. There is a system to identify residents who require monitoring of food intake. Specialised crockery and utensils are available to help promote independence at meal times. Residents were observed enjoying their lunch in one dining room. Residents' meetings allow for the opportunity for resident feedback on the meals and food services. Residents are complimentary of the food and confirm that alternative food choices are offered for dislikes. All staff who work in the kitchen have completed food safety and hygiene and chemical safety training. The kitchen has been verified by the Ministry of Primary Industries with this reviewed at the time of audit.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The reason for declining service entry to potential residents should this occur, is communicated to the potential resident or family/whānau and they are directed to the original referral agent for further information. The reasons for declining entry would be if the service had no beds available or could not provide the level of care.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments, including initial assessments had been completed for all long-term residents' files reviewed including one funded by ACC and one LTS-CHC. Resident files reviewed identify that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans, however not all wound care assessments had been completed appropriately (link 1.3.6.1).

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed overall demonstrated service integration and input from allied health (link 1.3.6.1). Resident care plans were resident centred and support needs and interventions were documented to reflect the resident goals, however not all care plans had been updated to reflect the resident's current health status (link 1.3.6.1). Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Residents (if appropriate) and family stated they were involved in the care planning and review process. Behaviour management including triggers, interventions and successful de-escalation techniques was included in the long-term care plan in two of the two residents with behaviour that challenges.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. Six of seven long-term care plans reviewed reflected the resident current needs and supports. The general practitioner interviewed was complimentary of the service and care provided. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included three chronic wounds, two skin tears, one grade 4 pressure injury and one abrasion. Wound documentation for a deteriorating pressure injury did not reflect the change and there was no referral to a wound care specialist. Monitoring forms are in use as applicable, such as weight, vital signs, and wounds. However, neurological observations had been documented as completed as per policy.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is one activity coordinator covering Monday to Friday who plans and leads all activities. The service designates weekends as 'family time' and also arranges activities on some 'themed' weekends such as Easter or Mother's Day. Residents were observed participating in planned activities during the time of audit. There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, happy hour, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo.

		Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered. There are regular outings, and the service utilises the adjoining village's accessible minibus. There are regular entertainers visiting the facility. Special events like birthdays, St Patrick's, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as churches and children's groups. Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Residents interviewed were very positive about the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary review (MDR) is also completed by the registered nurse with input from caregivers, the GP, the activities coordinator, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the majority of resident files (link 1.3.6.1). The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical manager interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurses identifies that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances	FA	Documented processes for the management of waste and hazardous substances are in place. Material safety datasheets were readily accessible for staff. Chemical bottles sighted have

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		correct manufacturer labels. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current building warrant of fitness, which expires on 30 October 2021. A request book for repairs is maintained and signed off as repairs are completed. There is a part-time maintenance officer who, with oversight of the village manager carries out the monthly planned maintenance programme. The village manager is on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually. All electrical equipment has been tested and tagged. Hot water temperatures have been tested (randomly) and recorded fortnightly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is wheelchair access to all areas including decks and landscaped external areas. The caregivers and RNs interviewed stated that they have all the equipment required to provide the care documented in the care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All resident rooms have a full ensuite. Handrails are appropriately placed in ensuite bathrooms and there is ample space to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Fixtures, fittings, floorings, and wall coverings are good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to	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. Residents are encouraged to personalise their bedrooms. Staff interviewed reported that rooms have sufficient space to allow cares to take place. Residents are encouraged to bring their own pictures, photos, and furniture to personalise their room, as observed during the audit.

the consumer group and setting.		
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large and small communal areas. There is a large main activities lounge, however activities occur in all areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting, and appropriate for the needs of the residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry has a dirty to clean workflow and a separate clean laundry sorting room. All linen and personal clothing is laundered on site. The chemical provider monitors the effectiveness of the laundry process. Cleaning trolleys are kept in designated locked cupboards when not in use. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits also monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for 3 litres per person, per day for 3+ days for resident use on site. There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty. Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night, with external gates being locked between 19.00 and 06.30. There is security lighting externally and CCTV covering entrances, exits and corridors.
Standard 1.4.8: Natural Light,	FA	All bedrooms and communal areas have ample natural light and ventilation. The facility has underfloor heating which is thermostatically controlled. Staff and residents interviewed, stated

Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (clinical manager) is an RN who is responsible for infection control across the facility as detailed in the infection control coordinator job description (signed copy sighted on day of audit). The coordinator oversees infection control for the facility, reviews incidents on the electronic resident management system and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of and completing the annual review of the infection control programme. Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There have been two outbreaks since the last audit which were well managed with appropriate referrals to, and input from public health and the DHB. Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE. The service also conducted regular PPE interactive demonstrations, with procedures being reinforced through the use of laminated pocket reference guides given to all team members. Other pandemic readiness strategies included the recording of staff 'bubbles' and documentation tracking dedicated staff allocations
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Terence Kennedy House. Information is shared as part of staff meetings and also as part of the registered nurse meetings. The infection control coordinator has completed annual training in infection control through the local DHB. External resources and support are available through an online learning portal, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP and clinical manager monitor the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies include 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. The policies have been developed by the facility management team in conjunction with an external specialist.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating education and ensuring staff complete the online training available on the 'Ko Awatea' internet based DHB education system. Training on infection control is included in the orientation programme. Registered staff have completed online infection control study in the last 12 months. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Terence Kennedy House surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the registered nurse and staff meetings. Meeting minutes are available to staff. Infections are entered into the electronic database to facilitate trend analysis. Corrective actions are established where trends are identified. The service also plans to commence benchmarking with its sister facility in the near future. 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. There were no residents using restraint and six residents using enablers (bedrails) on the day of audit. Three records around use of enablers were reviewed for three residents and all had assessments completed along with written consent. Staff interviews confirms their understanding of the differences between a restraint and an enabler. Staff receive regular training around restraint minimisation and the management of challenging behaviour that begins during their induction to the service.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There are systems and policies in place for self-medication by residents. There was one resident self-administered medications on the day of audit. GP review of the self-medication assessment and consent and security of medications were not completed according to policy.	One rest home resident who self-administer medications (inhaler) had not had a documented GP review of the self-medication assessment and consent in the last three months.	Ensure that the assessment and consent for self-medication is reviewed three-monthly 30 days
Criterion 1.3.6.1 The provision of services and/or	PA Moderate	All resident’s electronic clinical records reviewed included resident-focussed care plans, including short-term care plans for acute needs and changes to care. Six of seven long-term care plans reviewed	(i). Neurological observations were not consistently documented according to organisational policy for eleven falls which required neurological observations. Ten had	(i). Ensure neurological observations are

interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		reflected the resident current needs and supports. Resident and families agreed that the care provided was good and staff are caring and supportive. Wound documentation for a deteriorating pressure injury did not reflect the change.	fewer than the required minimum number of observations taken. (ii) One hospital resident's care plan did not document interventions to support pressure injury management. (iii) The wound care documentation for the same hospital resident did not reflect the deterioration from grade 2 to a grade 4 pressure injury. (iii) There was no referral to a wound nurse specialist for the hospital resident with a pressure injury that had deteriorated to grade 4.	documented as per organisational policy. (ii). Ensure care plan interventions reflect pressure injury management of a current pressure injury. (iii).Ensure wound care specialist input for deteriorating pressure injuries. 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.

No data to display

End of the report.