Kena Kena Rest Homes Limited - Kena Kena Rest Home

Introduction

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

The audit has been conducted by 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:	Kena Kena Rest Homes Limited
Premises audited:	Kena Kena Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 May 2021 End date: 11 May 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: 39

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

Kena Kena has been owned by the directors for 24 years. The service provides care for up to 41 residents requiring rest home level care. On the day of the audit there were 39 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 a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

Kena Kena rest home is owned and operated by three directors. Two of the directors are experienced registered nurses. Residents and family interviewed were very complimentary of the service and care they receive at Kena Kena rest home.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

This audit has identified two areas requiring improvement around new staff processes and education.

Consumer rights

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

The service adheres to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (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.		Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of monthly reviews. Quality and risk data is collected, analysed and discussed, and changes made as a result of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. There are robust human resource policies in place. An orientation programme is in place for new staff. Ongoing education for staff is provided.

The service is staffed well. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' 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.		Standards applicable to this service fully attained.

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.

Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is staff on duty 24/7 and on outings with a current first aid certificate.

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.		Standards applicable to this service fully attained.

Staff regularly receive training around restraint minimisation and the management of challenging behaviour. There are three resident requiring restraints and no enablers in use. There are processes, policies and procedure around restraint, and these are implemented.

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 owner/director/RN nurse manager has responsibility for infection control and collates the monthly infection data. The infection control coordinator has completed 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)
Standards	0	49	0	1	0	0	0
Criteria	0	99	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Families and residents are provided with information on admission which includes information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code). Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with three managers: two registered nurse directors (nurse managers) and one operations manager) and eight staff (four caregivers, one registered nurse (RN), one cook, one housekeeper, and one diversional therapist) reflected their understanding of the Code with examples provided of how it is applicable to their job role and responsibilities. Six residents and three relatives interviewed confirmed that staff respect their privacy and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	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 confirmed they were given good information to be able to make informed choices. 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 identified the service actively involves them in decisions that affect their relative's lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on resident's family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community with examples provided. Relatives and friends are encouraged to be involved with the service and care.
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 the complaints process. Complaints forms are made available at reception. Information about complaints is also provided on admission. Interviews with residents and families confirmed their understanding of the complaints process. The nurse manager was able to describe the process around reporting complaints, which complies with requirements set forth by the Health and Disability Commissioner (HDC). There is a complaint register available. Two verbal complaints for 2020 were fully addressed. One complaint for 2021 was regarding the laundry (which has been refurbished). The complaints process is linked to quality and risk management processes and quality meetings.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and their right to make a complaint. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information is provided to them about the Code. The registered nurse / nurse manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement and the ORA agreement for the residents in the studio units.

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	A tour of the premises confirmed there are areas that support personal privacy for residents. Resident rooms are large with ample room for visitors. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Caregivers were able to describe definitions around abuse and neglect. Residents and relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and include family involvement. Interviews with residents and family confirmed their values and beliefs are considered. This was also evidenced in the residents' files reviewed. Caregivers interviewed described how choice is incorporated into resident cares.
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 Māori health plan provides recognition of Māori values and beliefs. There are four residents who identify as Māori. Several staff are able to converse in te reo Māori. Māori holidays are celebrated (e.g., Waitangi Day). Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are assessed during the admission process and are addressed in the care plan. One resident who identified as Māori confirmed their individual needs were being met by the service. Staff were observed greeting residents in te reo Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Minutes are shared with all staff. Interviews with the managers and care staff confirmed their awareness of professional boundaries.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The two nurse managers and the operation manager are committed to providing services of a high standard; staff interviewed described the family approach to care and the high standard of care. This was observed during the day with the staff demonstrating a very caring attitude to the residents. Residents interviewed stated they are very happy with the level of care provided. Policies and procedures are developed by a contractor. The policies and procedures meet legislative requirements. There is a verbal and written handover for every shift that details any significant events. An electronic communication system is used to ensure staff are kept informed on daily matters. The building has recently been refurbished with new carpet, painting, a new laundry and a refurbished kitchen. An electronic assessment and care planning system has been introduced. Staff have all received training in its use and the system is being implemented.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All ten incident/accident reports reviewed meet this requirement. Families interviewed confirmed they are notified following a change of health status and/or accident/incident of their family member. There is an interpreter policy in place and contact details of interpreters are available. At the time of the audit, all residents spoke fluent English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The facility has been owned by the directors for 24 years. The directors also own another rest home facility (Kapiti) which is located nearby. The service provides care for up to 41 residents requiring rest home level care. On the day of the audit there were 39 residents, including one under the long-term chronic health condition contract and younger person under a residential disability contract, the remainder were funded through the age-related residential care contract. 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). There is a documented business plan for 2021 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 business plan includes continued environmental refurbishment. The previous year's plan included upgrades to the kitchen and laundry and implementing an electronic assessment and care planning system, which was in place at the time of audit. The nurse manager has attended at least eight hours of professional development relating to her role. The operations manager has a bachelor's degree in business management and human resources.
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 two owner/directors/nurse managers of each facility along with the registered nurse provide cover for each other's absence. They also share the on-call requirement.
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 documented quality/risk management plan is in place. The services policies are purchased from an external contractor who publishes updates as needed. Staff are informed regarding policy changes at meetings. The quality monitoring programme is designed to monitor aspects of service delivery. There are clear guidelines and templates for reporting. The facility collects, analyses and evaluates a range of data (e.g., falls, infections, pressure injuries, medication errors, restraint use, incidents, skin tears). Results are utilised for service improvements. Internal audits are conducted as per the internal audit schedule. Meetings include resident meetings, two monthly quality meetings and two to three monthly staff meetings. Minutes reviewed identified that quality data is shared with staff. Annual resident surveys have been conducted, outcomes of meetings have been communicated to respondents and to staff. The survey undertaken February 2021, documented increased satisfaction compared with 2020 around staff availability, and catering. Corrective action plans have been commenced for laundry services, with plans documented for cleaning. Health and safety policies are implemented. The nurse manager is the health and safety representative. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. External

		contractors and new staff undergo health and safety training during their orientation. Staff continue with regular health and safety training. Health and safety is a regular agenda item in the staff meetings. Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring for those residents at high risk of falling, and the identification and meeting of individual resident needs.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of eight fall related incident/accident forms identified that the incident/accident forms are fully completed and include follow-up by a registered nurse, including neurological observations. The incidence of falls has decreased from an average of eight falls a month March and April 2020 to an average of 5.6 for March and April 2021, with an overall downward trend over the year. The nurse manager and operations manager were able to identify situations that would be reported to statutory authorities. There have been no outbreaks since the previous audit. A Section 31 report has been completed for an RN shortage for interRAI (2020) and a missing controlled drug (March 2021).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one RN, one cook and seven caregivers) evidenced signed employment contracts and job descriptions and completed orientation programmes. Reference checking for new staff was not always documented. There is an implemented process for performance appraisals that begin during the new staff's orientation. The orientation programme provides new staff with relevant information for safe work practice. Orientation is specific to the individual's job role and responsibilities. Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted. There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Training is primarily evidenced through subject-specific questionnaires; however, most staff questionnaires have not been signed off as achieved. A register for each

		training session and an individual staff member record of training was verified. The registered nurses have completed interRAI training. Caregivers are supported to achieve their Careerforce qualifications. There are five caregivers with level four, ten at level three, and one at level one.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. 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 and Pink – 10 beds) and the nine studio rooms. The nurse manager is on site five days per week. 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. Staff are visible and attend to call bells in a timely manner as confirmed by all residents and relatives interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the RN and nurse manager provides good support. Residents and relatives interviewed reported there are sufficient staff numbers. The nurse manager is available on call if required. There is low staff turnover as reported by the care manager.
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 were 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held electronically using Leecare Solutions. They are protected from unauthorised access. Entries are computerised, dated and include the relevant caregiver or nurse including their designation. Individual resident files demonstrated service integration.
Standard 1.3.1: Entry To Services Consumers' entry into services is	FA	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

facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		agreements reviewed align with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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. The manager/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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	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 by the pharmacist (the most recent November 2020). Medications (blister packs) are checked on delivery against the medication chart and any discrepancies fed 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 and the treatment room are monitored daily. All eye drops were dated on opening. 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 records reviewed on the electronic medication administration system identified medications had been administered as prescribed. Prescribed 'as required' medications include the indication for use. The dose and time given is recorded on the electronic medication administration system. Staff were observed administrating medicines safely.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service	FA	All food is prepared and cooked on site at Kena Kena Rest Home. There are three cooks that cover the seven-day week. 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 (August 2019). A food safety plan expires November 2021. 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

delivery.		allergies are known and accommodated. The meals were well-presented, and residents confirmed that they are provided with alternative meals as per request. 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.
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	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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN or nurse manager completes an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier due to health changes for long-term residents. 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.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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 and 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. 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. There was evidence of allied health care professionals involved in the care of the resident.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	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. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan (include dressing type and evaluations on change of dressings) were in place for one unstageable pressure injury and one stage one, a surgical wound (skin graft and donor site) and a skin tear. There is access to a wound nurse specialist and DHB plastics department for advice for wound management. Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activity programme is led by a diversional therapist and two activity staff who between them, provide a programme over six days a week. The activity programme is planned in advance and residents have copies in their rooms with the current week displayed throughout the facility. Activities include (but are not limited to); newspaper reading, walks, quizzes and word games, bowls and weekly happy hour with entertainment. There are also van trips, trip to the cinema, stroke club, and library. There are visits from the kindergarten, schools and the kapa haka group. For the younger person, there are trips to cafés, clubs, hot chips and family trips. Other residents also join in. One-on-one time is spent with residents who prefer to stay in their room. Residents have an assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family etc. A leisure care plan and social activity is completed for each resident. Resident meetings and surveys provide residents and relatives an opportunity to provide feedback on the activity programme. Residents and relatives interviewed were satisfied with the activities provided. Residents were observed participating in activities on the days of audit.
Standard 1.3.8: Evaluation	FA	Initial care plans reviewed were evaluated by the RNs within three weeks of admission and a

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		long-term care plan developed. Long-term care plans had been evaluated six- monthly for all of the seven resident files reviewed. Written evaluations 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.
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	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. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	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 days of audit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is an operations manager who oversees the facility operation and maintenance at Kena Kena and the sister home. One of the three directors is the onsite 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 2021. 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. The RN and care staff interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury resources, and a hoist (for use in the case of falls and one for standing transfers) to safely deliver the cares as outlined in the residents' care plans. Residents interviewed confirmed they are able to move freely around the facility.
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 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 an ensuite. 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.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All 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.
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	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.
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	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,

service is being provided.		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.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency, disaster policies and procedures are documented for the service. There is an evacuation scheme that has been approved by the fire service. 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 an emergency water supply stored in a tank underground. There is a generator on site and directions to use should this water be required. Emergency civil defence supplies are all checked six-monthly. A gas BBQ is available for alternate cooking. There is emergency lighting, and the service has the above mentioned generator. 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.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	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.
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	FA	The nurse manager has overall responsibility for infection control and the collation of infection events. She is supported by the nurse manager of the sister home and the registered nurse. The infection control policies and procedures are reviewed two yearly (2020) and the programme is reviewed annually. Advice and guidelines relating to Covid from the DHB and Ministry of Health had been incorporated in the 2020 review. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the

size and scope of the service.		facility. Residents and staff are offered the influenza vaccine. There have been no outbreaks since the previous audit. Management understood requirements relating to notification should an outbreak occur. In August 2020 a full day of education was held – the topic covered 'Infection Control and Management in a Viral world' During 2020 the DHB & MOH guidelines were followed and a skype meeting with the DHB was held on preparedness for an outbreak. The IC nurse from the DHB visited the site to determine readiness for an outbreak. Suggestions were followed and a plan to isolate one section of the home(Peach wing) should there be an outbreak was prepared.
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	The infection control coordinator has completed an infection control & management days study in August 2020. 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.
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 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.
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/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. Resident education is expected to occur as part of providing daily cares.

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	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. 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	Restraint practices are only used where it is clinically indicated and justified, and other strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. There were three residents with restraints including one bedrail and three brief restraint (one resident had two) at the time of the audit. Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.
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 responsibilities for the restraint coordinator (the nurse manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation	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 GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.

to use of restraint.		Ongoing consultation with the resident and family/whānau are evident. Two residents' files where restraints were in use were selected for review. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	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 residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at least two hourly and the residents are most commonly in the main lounge with the care staff during the day. Monitoring was consistently and accurately documented on the restraint monitoring records reviewed. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.
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). Two resident files where restraint was in use documented a monthly review through the quality meetings, three monthly GP review and six-monthly review as part of the care plan evaluations with family. There is also a three-monthly individual audit for each resident to ensure that processes are in place, to review if any accidents/incidents have occurred and if there has been any impact culturally or on behaviour.
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 reviewed as part of the policy review process and as part of the quality meetings. Restraint education and training is completed annually. Internal restraint audits are completed monthly.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Nine staff files were reviewed and all documented signed employment contracts and job descriptions and completed orientation programmes. Reference checking for new staff was not always documented.	Of the nine staff files, seven were for staff who had been employed since the previous audit. Of the seven, three did not document that reference checks were in place.	Ensure that reference checks are documented for all new staff 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is an education plan documented and staff most commonly evidence training through the completion of subject-specific questionnaires. Most questionnaires had not been signed as achieved.	Of the nine staff files reviewed all had instances of education questionnaires with no checks or sign off.	Ensure that staff education questionnaires are checked and signed off.

				90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.