

Keringle Park Limited

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Keringle Park Limited
Premises audited:	Keringle Park Residential Care
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 22 March 2016 End date: 22 March 2016
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:	30

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

Keringle Park Residential Care (Keringle Park) is privately owned and provides rest home level care for up to 33 residents. This includes a 12 bed secure dementia care unit.

This spot surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of relevant policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management and staff. The general practitioner was not available for interview.

There were no areas for follow up from the previous audit.

Consumer rights

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

The service has a documented complaints management system which is implemented. There were no outstanding complaints at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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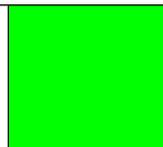
Keringle Park has a business plan which covers all aspects of service delivery planning. The business plan is reviewed annually by the manager and external quality provider to identify if documented service planning meets the needs of residents. The mission statement and philosophy are documented and reflected in the quality and risk management system in place.

The quality and risk management systems, which include internal audits, complaints management, incident and accident processes and infection control, are implemented and understood by staff. Quarterly quality management reviews show trended data results which are shared at staff meetings. The manager works at the facility and is aware and involved in all quality improvements. Quality and risk management activities and results are shared with residents and family/whānau as appropriate. Corrective action planning occurs as required.

Good human resources practices are implemented. The staffing skills mix is appropriate for level of service offered. Every shift is covered by a staff member who holds a current first aid certificate. As confirmed during resident and family/whānau interviews, residents' needs are met.

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.

Services are provided by suitably qualified and skilled staff to meet the needs of the residents. The interRAI assessment process is in progress and all residents have an interRAI assessment completed. Timeframes for the development and review of long term care plans are met. Short term plans are developed when there are changes in the resident's needs that are not addressed on the long term care plan.

The general practitioner (GP) reviews all residents medically within the required timeframes and more frequently as needed. Pressure injury management and responsibilities are documented in policy and implemented. The clinical manager is fully informed in relation to reporting requirements for any pressure injuries.

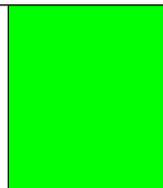
The FM is actively recruiting a permanent person for activities coordinator and this area is being covered by staff in the meantime.

A safe medication system was observed during the audit. The staff responsible for medication management have completed comprehensive competencies to perform this role.

The residents' nutritional requirements are met by the service with preferences and special diets being catered for. The staff who prepare meals are experienced and prepare meals from a menu plan which has been approved by a dietitian.

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.

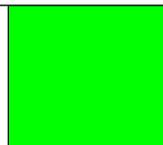


Standards applicable to this service fully attained.

The building has a current building warrant of fitness. There have been no changes made to the building footprint since the previous audit.

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.

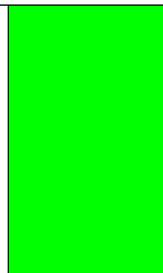


Standards applicable to this service fully attained.

There are no restraints or enablers in use at the time of audit. Policy describes enablers as being voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education planning process.

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 prevention and control management system is appropriate for the nature of the service. The risk of infection is reduced for residents, staff, families/whanau and visitors.

The clinical manager, who is the infection control co-ordinator, collates the monthly surveillance data and this is sent to a contracted infection control management service to analyse and to report back on any trends and if any identified action is to be implemented. The infection surveillance results are reported at the staff two monthly meetings. Expertise is available and can be sought as required.

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	16	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Keringle Park implements the complaints policy and procedure to ensure all complaints are documented and responded to in a timely manner. The complaints information sighted identified the issue, the date received and the date the complaint was closed off. There are no open complaints at the time of audit.</p> <p>The manager confirmed complaints management information is used as an opportunity to improve services as required. Complaints processes are explained during the admission process as confirmed during resident and family/whānau interviews.</p> <p>Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive</p>	FA	<p>The service promotes an environment of full and frank information sharing. Policies and procedures are in place if interpreter services are needed.</p> <p>The family/whānau interviewed confirmed they are kept informed of their relative's condition and they are informed if staff have any worries or concern.</p> <p>The CM and senior caregiver interviewed understood the principles and practice around open disclosure and that residents have a right to full and frank information. The RNs and caregivers have received training and</p>

to effective communication.		<p>this is documented in the training records and individual staff records reviewed.</p> <p>Evidence is seen of family contact in all residents' files reviewed. The residents/families interviewed reported they are consulted and contacted with any issues regarding the residents care.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business plan sighted is reviewed annually. This was last undertaken in August 2015. There are specific goals and objectives covering all aspects of the business and quality planning for Keringle Park. The organisation's goals and objects are reported against quarterly. The quality and risk plan details the known risks, current controls and ongoing actions taken to limit risk. The mission statement and organisational philosophy are documented.</p> <p>On the day of audit there were 19 rest home level care and 11 secure dementia care residents.</p> <p>The manager has worked at the facility for 17 years and is responsible for all non-clinical services. The clinical manager is a registered nurse who has worked at the facility many years and is experienced in aged care. Roles and responsibilities are identified in job descriptions sighted and during interview management reported how they work within their set scope of practice. Both managers attend ongoing education related to the roles they undertake.</p> <p>Interviews with residents and family/whānau members confirmed that their needs were met by the service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Staff confirmed during interview that the quality and risk management systems documented are understood and implemented during service delivery. These processes include regular internal audits, incident and accident reporting and analysis, health and safety monitoring, infection control management and data recording and complaints management processes. If an area of deficit is found corrective measures are put in place to address the situation. For example, when falls rates increased in the secure dementia care unit (the cottage) in April 2015 appropriate actions were documented and implemented resulting a 50% decrease in falls over the preceding three months.</p> <p>Monthly quality data evaluations and corrective actions are shared with all staff as confirmed in meeting minutes and verified by staff during interview. The quality data results are reported to staff in a manner that is easily understood. Quarterly quality reviews are undertaken for all key components of service and presented in graph form with comparisons of previously collected data to identify trending. Quality data information is used by management to inform ongoing service planning and to ensure residents' needs are being met. The quality improvements (corrective actions) put in place are documented with pictorial evidence wherever possible.</p> <p>Policies sighted are all current and referenced to identify best practice data. This process is managed by an</p>

		<p>off-site provider. Policies are individualised to Keringle Park as appropriate.</p> <p>Actual and potential risks are identified and documented in the risk register which covers all aspects of service provision. Newly identified hazards are documented in a hazard book and shows how the hazard is managed. These are discussed at handover and staff meetings as confirmed during staff interviews and in meeting minutes sighted. Staff confirmed that they understood and implemented documented hazard identification processes. All hazards are reviewed at least annually during the annual review process in August. Hazards are communicated to family/whānau and residents as appropriate.</p> <p>Residents and families/whānau interviewed confirmed they are happy with the services provided.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Policy is in place to inform staff about how to manage adverse event reporting. The service records all incidents and accidents and data is collected and reported electronically at each staff meeting. This is confirmed in meeting minutes sighted. Any follow up required is undertaken in a timely manner by the clinical manager. Staff interviewed report they understand and implement reporting of all adverse events using incident and accident forms.</p> <p>Documentation confirms that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. Incident and accidents are reported to family/whānau as confirmed on the incident and accident forms sighted and during family/whānau interviews.</p> <p>The manager and clinical manager confirmed their understanding related to the obligations in relation to essential notification requirements. A discussion was held related to reporting serious harm accidents, pressure injuries and infections. Documentation sighted shows that serious harm accidents such as fractures are registered with Work Safe, ACC and a medical practitioner. The correct use of section 31 reporting forms is now fully understood by management owing to education undertaken one week prior to audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures identify human resources management practices that reflect good employment practice and meet the requirements of legislation, are implemented by the service. Job descriptions clearly describe staff responsibilities and accountabilities. Six staff files reviewed identify that staff have completed an orientation programme with specific competencies for their roles. The clinical manager has a documented system in place to assist with keeping staff annual appraisals up to date. The cook's appraisal was not up to date and this was completed on the day of audit. (This is not a systemic issue).</p> <p>The annual education calendar identified the education undertaken by staff covers all aspects related to care provision. Education included both on and offsite training sessions. This was confirmed in the education records sighted for all staff. Staff who work in the dementia unit hold recognised specific qualifications related to dementia care. Staff meetings minutes identify that it is a requirement for staff to undertake nominated</p>

		<p>compulsory education which is monitored by the clinical manager.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually.</p> <p>Resident and family/whānau members interviewed identified that residents' needs are met by the service in a professional manner.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service implements policy related to staff skill mixes and experience. This is reflected in the seven weeks of rosters sighted and meets contractual requirements. Every shift is covered by a staff member with a current first aid certificate.</p> <p>A review of the rosters showed that staff are replaced when on annual leave or sick leave. Staff interviewed reported that they sometimes do not complete their workload but that it is never an issue if they remain to complete a task, for which they are paid. This was discussed with management who stated they understand that there is often a variance in the required hours depending of resident acuity and needs. They said hours are increased if the resident requirements increase for any reason. The manager recognised that the 7am to 1pm shift in the rest home needs to be increased on the roster as nine of the past 14 days an additional half hour has been required by staff. She stated that she had not yet managed to change the hours shown on the roster but that she intended to do so.</p> <p>Residents and family/whānau confirmed during interview that services are delivered in a safe, timely and homely manner and that residents' needs are met.</p> <p>The clinical manager works Monday to Friday and is on call. On call is shared between two RNs. There are dedicated kitchen staff. At the time of audit there is no activities coordinator employed but the service can show they are actively recruiting for the role. (Refer comments in standard 1.3.7).</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The lunchtime medication round was observed and a safe process was observed. The GP was not available for interview and the registered nurses can notify the GP with any queries or points of clarification as needed.</p> <p>The medication records randomly selected had been reviewed by the GP and any allergies/sensitivities are entered to alert staff. A system is in place for returning any unused or outdated medication to the contracted pharmacy. These are recorded and monitored.</p> <p>The medication room is in close proximity to the nurses' station and a medication trolley is available and is locked when not in use. Controlled drugs are managed correctly and meet legislative requirements.</p> <p>There is only one resident who self-medicates. A self-medication policy is in place. The GP has consented to</p>

		<p>the resident being able to self-medicate.</p> <p>The medication fridge is monitored on a daily basis and the temperatures recorded, which meets requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Policies and guidelines are available. The menu plans have been reviewed by a registered dietitian and a letter is available to verify this has occurred. The cook and kitchen hands have all completed food handling training. The food safety management education is appropriate for service delivery.</p> <p>There are separate cleaning schedules for the kitchen. Temperature monitoring requirements are met. The cook orders all food and checks deliveries, storage and manages the waste management appropriately. All food is correctly labelled. The kitchen is clean and functional and is in the centre of the facility.</p> <p>A nutritional assessment is performed by the registered nurse with the resident/family/whanau as part of the admission process. A copy is provided to the cook. Any resident preferences, special diets, likes/dislikes are documented. Special days are celebrated, such as birthdays, and are catered for by the cook and kitchen hands.</p> <p>Annual service satisfaction surveys are completed by residents/family and this includes the food service. The families and residents interviewed reported satisfaction with the meals provided. Fluid rounds, morning and afternoon teas are provided and fresh baking is available. The lunch was served in the dining room in both the rest home and dementia unit. Food is available over 24 hours for all residents including the dementia unit.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Support and care is individualised and focused on achieving desired outcomes/goals set. The registered nurses and care staff interviewed demonstrated appropriate skills and knowledge of the individual needs of all residents. The records reviewed showed evidence of consultation and involvement of the resident and family as able. The residents interviewed reported satisfaction with the care and services provided. One family member interviewed spoke highly of the care provided and the interaction of staff with individual residents and the homeliness of the environment.</p> <p>Short term care plans are developed and implemented as necessary for any event that is not part of the long term care plan, such as unexplained weight loss or wound care management. The registered nurses ensure the GP is kept well informed of progress.</p> <p>There are adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed demonstrated interventions that are consistent with the resident's needs being able to be met. Observations on the day of the audit indicated residents are receiving care that is consistent with meeting their assessed needs. The senior caregiver interviewed reported that service delivery is in line with the</p>

		residents' care plans.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Evidence was seen of completed documentation on admission and an activity plan and activities are being undertaken routinely. The manager is actively recruiting an activities coordinator and in the meantime other staff are undertaking this role.</p> <p>NZQA training is available for all care staff and especially for those working in the dementia unit. Care staff are under taking the standards relating to contractual requirements for working secure units.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluation of care plans occurs six monthly or earlier as applicable. Evaluations are focused and indicate the degree of achievement or response to support/interventions and progress towards meeting the set goals. If a resident's needs change or if the resident is not responding appropriately to the interventions being delivered then this is discussed with the GP, the resident and the family. Short term care plans are initiated as needed.</p> <p>The care staff interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared in the handover between shifts. Progress is also discussed at the six monthly reviews.</p> <p>Families reported that they are consulted when staff have any concerns or when there are changes to the resident's condition. This is documented on the family communication records as evidenced in the records reviewed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Documentation identifies all processes are maintained for the facility's current building warrant of fitness which expires on 10 June 2016. There have been no changes made to the footprint of the building since the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>The infection prevention and control surveillance that is undertaken is appropriate to the size of this aged care setting as demonstrated in the infection control programme. All staff are involved. An infection form is</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>completed as soon as signs and/or symptoms have been identified and given to the registered nurses. Monitoring is described in the infection control plan to ensure residents` safety.</p> <p>The infection prevention and control co-ordinator is currently the CM who completes the monthly surveillance reports. Monitoring occurs for any urinary infections, eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections as required. The infection control nurse compares results with previous reports, reasons for any increase or decrease and/or trends are identified. The results are reported back to staff at the staff meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policy clearly describes enablers as voluntary and the least restrictive option to meet residents' needs. The facility was restraint free at the time of audit and there are no enablers in place. Staff confirmed during interview that the annual education undertaken has given them a very clear understanding of what is required should any form of restraint be required.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.