Keringle Park Limited

Current Status: 11 September 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Keringle Park is privately owned and operated by a husband and wife team who both work in the facility on a daily basis. They have owned the facility for over 16 years. There are two clinical nurse managers who job share, that oversee all clinical services. The service offers rest home and secure dementia care. On the day of audit there are 29 rest home residents, with 11 residents receiving dementia care.

There are no areas identified as requiring improvement in this audit. The requirements of the provider's agreement with the district health board are met.

Audit Summary as at 11 September 2014

Standards have been assessed and summarised below:

Key

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
	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

Indicator	Description	Definition
	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

Consumer Rights as at 11 September 2014

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.

Organisational Management as at 11 September 2014

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.

Continuum of Service Delivery as at 11 September 2014

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.

Safe and Appropriate Environment as at 11 September 2014

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.

Restraint Minimisation and Safe Practice as at 11 September 2014

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.

Infection Prevention and Control as at 11 September 2014

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.

Audit Results as at 11 September 2014

Consumer Rights

Services are provided in a manner that are respectful of residents' rights and facilitates informed choice and consent. Residents and family interviewed expressed their satisfaction with services and believe staff are providing appropriate care and that they are treated with respect and dignity.

The Code of Health and Disability Services Consumers` Rights (the Code) was clearly displayed along with the complaints forms. Staff and residents are well informed about the residents` rights and advocacy services. The residents' advocate telephone number and pamphlet was displayed.

Cultural values and beliefs are taken into consideration at all stages of service delivery. The service has a policy documented and implemented on open disclosure and good communication was evident between the clinical manager and the general practitioners.

The service has a documented complaints management system which is implemented. There are no outstanding complaints at the time of audit. There is one open coroner's case which was opened in August 2014. A preliminary result has been given and the final ruling is pending.

Organisational Management

The organisation's values, goals and mission statement are identified in the business plan. This document identifies how services are planned and coordinated to meet residents' needs. The quality and risk plan shows the measures taken to deliver services in a safe and effective manner. The service has very clear systems implemented to manage any areas of concern or deficits found. Issues are managed through corrective action planning as appropriate.

Quality of service is reviewed and measured via the internal audit process, complaints management, resident and family/whānau satisfaction survey results,

along with infection control and adverse event data collection and review. Quality and risk activities and results are shared among all staff and with residents as appropriate. Two criteria have achieved continuous improvement ratings as the service clearly demonstrated that review processes including analysis and reporting of findings, evidence of actions taken based on those findings resulted in improvements to service provision, resident safety and satisfaction.

The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. All staff have ongoing training that includes recognised approved training standards which encompass dementia care. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whānau interviews and in the 2014 satisfaction survey results.

Policy identified that accurate information was entered upon a resident`s admission. The organisation meets all health record management and legislative requirements.

The service implements documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

Resident information is accurately recorded, current and stored appropriately to ensure privacy.

Continuum of Service Delivery

The residents` records provide evidence that all residents have been assessed appropriately prior to admission to the facility by the geriatrician or the needs assessment service co-ordinators for the DHB. The service has well implemented systems to assess, plan and evaluate the care needs of the residents. The residents` needs, outcomes and/or goals had been identified and these are reviewed on a regular basis with resident and/or family input. A team approach to service delivery and continuity of care is encouraged and promoted

Medication management is safely implemented. A visual inspection of the medication system utilised and the lunchtime medication rounds in the rest home and the dementia unit provided evidence of compliance with legislative requirements, regulations and guidelines. There is evidence of the general practitioners reviewing medication three monthly, or more often if required. The pharmacy audits occur twice a year and are conducted by the contracted pharmacist. The general practitioner interviewed is satisfied with the communication between the pharmacist, the clinical managers and the general practitioners who cover this service.

The activities programme is provided and enjoyed by the residents in the rest home and the dementia services. Participation is encouraged but is voluntary. Activities are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Outings in the community are arranged and

entertainers and visitors from the community are welcome to participate in the programme.

Food service policies and procedures are appropriate for the service settings. The service is managed by and experience registered chef and catering manager. The meu plans have been reviewed by a qualified dietitian. The four weekly menus are documented and displayed. The individual dietary needs identified during the assessment process, or any changing needs, are addressed and choices are provided. Meals are served at appropriate times of the day and additional food is always available for the dementia service and other services.

Safe and Appropriate Environment

Keringle Park has documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. Fire evacuations and emergency education is undertaken as part of staff orientation and ongoing education. The building has a current building warrant of fitness and the service has an approved fire evacuation plan.

The facilities are fit for purpose and provide furnishings and equipment that are appropriately maintained to meet residents' needs. Residents' bedroom areas meet the needs of residents and allow personal belongings to remain safe. Bedrooms with more than one bed have curtains for visual privacy. There is adequate toilet, bathing and hand washing facilities. Each of the three dwellings on the site have clearly designated lounge and dining areas which meet residents' relaxation, activity and dining needs.

The facility is electrically heated and is ventilated through opening doors and windows. There are appropriate outdoor areas for residents in the rest home and secure dementia areas.

Restraint Minimisation and Safe Practice

Policy clearly describes that enablers are voluntary and the least restrictive option. The service has no enablers or restraint in use at the time of audit. Staff undertake regular restraint education should it be required at any time.

Infection Prevention and Control

The service has infection prevention and control policies and procedures relevant to the level of care provided. The surveillance programme was adequate for the size and nature of this aged care residential service. The clinical nurse was very experienced and well educated to perform this role effectively. Surveillance

management was well documented and any information was fed back to the staff and all data was analysed and comparisons made of previous months.

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Keringle Park Limited
Certificate name:	Keringle Park Limited

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Certification Audit
Premises audited:	Keringle Park Residential Care
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	**Start date:** 11 September 2014 **End date:** 12 September 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	29

Audit Team

Lead Auditor	XXXXXX	**Hours on site**	16	**Hours off site**	12
Other Auditors	XXXXXX	**Total hours on site**	16	**Total hours off site**	8
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXX			**Hours**	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	24	Total audit hours	56

Number of residents interviewed	6	Number of staff interviewed	7	Number of managers interviewed	4
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	4
Number of medication records reviewed	12	Total number of staff (headcount)	20	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Friday, 10 October 2014

Executive Summary of Audit

General Overview

Keringle Park is privately owned and operated by a husband and wife team who both work in the facility on a daily basis. They have owned the facility for over 16 years. There are two clinical nurse managers who job share, that oversee all clinical services. The service offers rest home and secure dementia care. On the day of audit there are 29 rest home residents, 11 of whom are in the secure dementia care area known as 'the cottage'.

There are no areas identified as requiring improvement in this audit. Organisational management has gained a continuous improvement rating.

The requirements of the provider's agreement with the district health board are met.

Outcome 1.1: Consumer Rights

Services are provided in a manner that are respectful of residents' rights and facilitates informed choice and consent. Residents and family interviewed expressed their satisfaction with services and believe staff are providing appropriate care and that they are treated with respect and dignity.

The Code of Health and Disability Services Consumers` Rights (the Code) was clearly displayed along with the complaints forms. Staff and residents are well informed about the residents` rights and advocacy services. The residents' advocate telephone number and pamphlet was displayed.

Cultural values and beliefs are taken into consideration at all stages of service delivery.

The service has a policy documented and implemented on open disclosure and good communication was evident between the clinical manager and the general practitioners.

The service has a documented complaints management system which is implemented. There are no outstanding complaints at the time of audit. There is one open coroner's case which was opened in August 2014. A preliminary result has been given and the final ruling is pending.

Outcome 1.2: Organisational Management

The organisation's values, goals and mission statement are identified in the business plan. This document identifies how services are planned and coordinated to meet residents' needs. The quality and risk plan shows the measures taken to deliver services in a safe and effective manner. The service has very clear systems implemented to manage any areas of concern or deficits found. Issues are managed through corrective action planning as appropriate.

Quality of service is reviewed and measured via the internal audit process, complaints management, resident and family/whānau satisfaction survey results, along with infection control and adverse event data collection and review. Quality and risk activities and results are shared among all staff and with residents as appropriate. A continuous improvement rating has been obtained as the service, having fully attained all criteria in this standard, can in addition clearly demonstrate review processes which include analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision which improve resident safety and satisfaction as a result of the follow up actions taken.

The day to day operation of the facility is undertaken by staff that are appropriately experienced and qualified. All staff have ongoing training that includes recognised approved training standards which encompass dementia care. This allows residents' needs to be met in an effective, efficient and timely manner, as confirmed during resident and family/whānau interviews and in the 2014 satisfaction survey results.

Policy identified that accurate information was entered upon a resident`s admission. The organisation meets all health record management and legislative requirements.

The service implements documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

Resident information is accurately recorded, current and stored appropriately to ensure privacy.

Outcome 1.3: Continuum of Service Delivery

The residents` records provide evidence that all residents have been assessed appropriately prior to admission to the facility by the geriatrician or the needs assessment service co-ordinators for the DHB. The service has well implemented systems to assess, plan and evaluate the care needs of the residents. The residents` needs, outcomes and/or goals had been identified and these are reviewed on a regular basis with resident and/or family input. A team approach to service delivery and continuity of care is encouraged and promoted

Medication management is safely implemented. A visual inspection of the medication system utilised and the lunchtime medication rounds in the rest home and the dementia unit provided evidence of compliance with legislative requirements, regulations and guidelines. There is evidence of the general practitioners reviewing medication three monthly, or more often if required. The pharmacy audits occur twice a year and are conducted by the contracted pharmacist. The general practitioner interviewed is satisfied with the communication between the pharmacist, the clinical managers and the general practitioners who cover this service.

The activities programme is provided and enjoyed by the residents in the rest home and the dementia services. Participation is encouraged but is voluntary. Activities are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Outings in the community are arranged and entertainers and visitors from the community are welcome to participate in the programme.

Food service policies and procedures are appropriate for the service settings. The service is managed by and experience registered chef and catering manager. The meu plans have been reviewed by a qualified dietitian. The four weekly menus are documented and displayed. The individual dietary needs identified during the assessment process, or any changing needs, are addressed and choices are provided. Meals are served at appropriate times of the day and additional food is always available for the dementia service and other services.

Outcome 1.4: Safe and Appropriate Environment

Keringle Park has documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances generated during service delivery. Fire evacuations and emergency education is undertaken as part of staff orientation and ongoing education. The building has a current building warrant of fitness and the service has an approved fire evacuation plan.

The facilities are fit for purpose and provide furnishings and equipment that are appropriately maintained to meet residents' needs. Residents' bedroom areas meet the needs of residents and allow personal belongings to remain safe. Bedrooms with more than one bed have curtains for visual privacy. There is adequate toilet, bathing and hand washing facilities. Each of the three dwellings on the site have clearly designated lounge and dining areas which meet residents' relaxation, activity and dining needs.

The facility is electrically heated and is ventilated through opening doors and windows. There are appropriate outdoor areas for residents in the rest home and secure dementia areas.

Outcome 2: Restraint Minimisation and Safe Practice

Policy clearly describes that enablers are voluntary and the least restrictive option. The service has no enablers or restraint in use at the time of audit. Staff undertake regular restraint education should it be required at any time.

Outcome 3: Infection Prevention and Control

The service has infection prevention and control policies and procedures relevant to the level of care provided. The surveillance programme was adequate for the size and nature of this aged care residential service. The clinical nurse was very experienced and well educated to perform this role effectively. Surveillance management was well documented and any information was fed back to the staff and all data was analysed and comparisons made of previous months.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	45	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Quality improvement data is collected for all aspects of the service. Staff meeting minutes and staff interviews confirms they are consulted, have input into and are kept fully informed of all processes. Residents are informed of any changes to be made to services and this is discussed at two monthly resident meetings. A continued improvement rating has been obtained as the service, having fully attained this criterion can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision and resident safety and satisfaction as a result of the review process.
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	CI	A review of 2014 corrective action plans identify that all areas where a deficit is found has a corrective action placed around it which is documented to show what action is to be taken to correct this, who is to be responsible for ensuring the action is completed and a completion date. All corrective actions are reviewed and signed off by management when completed. Once the corrective action has been in place for a set period of time it is reviewed to ensure it is working to the advancement of the services being delivered. A continued improvement rating has been obtained as the service, having fully attained this criterion can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision and resident safety and satisfaction as a result of the review process.

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA

Evidence:

Staff receive education and are able to demonstrate knowledge and understanding of residents' rights and obligations and apply this as part of their everyday practice. Interviews with staff, including two clinical managers, four of four caregivers and two of two registered nurses, indicate that staff are familiar with informing residents of the Health and Disability Services Code of Consumers' Rights (the Code). Residents and family members interviewed confirmed that they have been informed of the Code of Rights on admission to this service.

Staff education programmes and orientation packages reviewed verified that ongoing education on consumer rights and obligations is provided to all staff. Seven of seven staff confirm they have received appropriate training on the Code. Tapes and DVDs from the Health and Disability Commissioner`s office are available for training purposes. Pamphlets and booklets are accessible around the facility on the Code and implications of the Code.

The district health board contract requirements are met.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

Policy identifies that opportunities are provided for explanations, discussion and clarification about the Code of Health and Disability Services Consumers' Rights. Residents are informed of their rights by both pre-admission and admission information being provided. Both the Code and advocacy details are displayed and are accessible. The information and admission packs include pamphlets on the Code and information is displayed in prominent places throughout all areas of the rest home and dementia unit.

The residents` rights policy demonstrates consistency with the Code. The resident admission agreement reviewed includes information on the Code of Rights. An independent resident advocate is available called 'Crossroad` and contact details are on the pamphlet displayed in the hallway of the rest home.

The district health board contract requirements are met.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: FA

Evidence:

Policy is in place related to ensuring staff deliver services to resident's that reflect independence, privacy, dignity and respect. This includes policy covering abuse and neglect. Processes are in place and seven of seven staff interviewed are fully aware of responsibilities and reporting obligations. Training is

provided on abuse and neglect (last provided/recorded on the 9 July 2014). The GP and seven of seven residents at interview have a good understanding of abuse and neglect. Five of five family stated that staff are respectful at all times.

Personal privacy is respected and signage is on the bathroom doors and the doors are lockable. There are curtains in the residents' shared rooms in the dementia unit. There are two double rooms in the rest home, one has a married couple sharing the room, and in the other room there is only one resident.

There are many different staff nationalities, including English, Indian, Pacific Island, Niuean, Cook Island, Fijian Indian and others.

The residents also confirm that this is a comfortable place to live in and their rights are respected.

Residents` files sighted include person centred care plans that document support and interventions to meet the resident`s needs, individual preferences and chosen lifestyle. Spiritual and cultural needs identified are also addressed. All residents are called by their preferred name as documented on their individual record.

The district health board contract requirements are met.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA

Evidence:

Policy documents a process to guide staff when developing a Maori resident's health care plan. This includes management of death and dying. Cultural safety guidelines are clearly documented and show how barriers to care are managed via appropriate health practices. This includes involvement of whanau in care provision and decision making as appropriate. A specific assessment plan for Maori residents is in place that reflects aspects of the Treaty of Waitangi. The resident's rights and privacy policy are printed in English and te reo Maori.

A cultural assessment and person centred cultural plan was sighted in one of the resident's records reviewed. There are currently two residents who identify as Maori and six staff who identify as Maori. Staff interviewed are able to identify specific strategies that have been implemented to ensure that the service is culturally safe. The service acknowledges the Treaty of Waitangi. The Cultural Awareness Policy is available to guide staff with information to provide appropriate service provision. In addition to this policy the service has a documented Maori Health Policy to meet the service agreement obligations, that includes a plan for addressing objectives set. Seven of seven staff interviewed confirm that they are aware of the need to respond appropriately to individual cultural difference. One family member at interview stated that staff respect the particular cultural needs of his wife who identifies as Maori. Visitors and whanau are welcome to visit.

The district health board contract requirements are met.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)
Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)
The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

Policy identifies that the service respects and recognises cultural values and beliefs of all residents, family/whanau and staff. The interpreter policy guides staff actions related to use and to ensure all residents' rights to appropriate communication and understanding are met. During the admission process, the clinical nurse manager and/or registered nurses, along with the resident and family/whanau, complete the relevant documentation. A personalised cultural person centred care plan is developed and implemented as well as the comprehensive person centred care plan.

The six of six residents' records reviewed include the individual resident`s social, spiritual and cultural values and beliefs. Culturally safe practices are implemented and are being maintained. Tikanga practices are adhered to by staff and respected.

The district health board contract requirements are met.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Policy is in place to identify that residents will be free from any form of discrimination, coercion, harassment, sexual, financial or other exploitation. There is a clearly set out staff code of ethics. Staff clearly understand the need to work within their job description boundaries. The policies include support for the resident throughout their engagement with this service. Training is provided annually in regards to the Code and advocacy, privacy and complaints. Complaints forms are readily available in the rest home and the dementia unit. Family interviewed (five of five) are fully aware of how to make a complaint if and when required.

All clinical and non-clinical staff employed have job descriptions and are aware of the house rules for this service as part of the employment protocol. A copy of the job descriptions and responsibilities is retained in each staff record reviewed. Seven of seven staff records were randomly selected for review. Staff at interview state they understand the required line of reporting should they have any concerns.

The district health board contract requirements are met.

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

The service has policies and procedures and associated implemented systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards – including those standards relating to the Health and Disability Services (Safety) Act 2001. Services are provided at Keringle Park rest home and dementia unit that adhere to the Health and Disability Services standards.

There is an implemented quality improvement programme that includes performance monitoring. Residents and family members interviewed spoke very positively about the care provided. The care planning and evaluation process is well implemented by the two clinical managers. Staffing evaluations for the current year against the documented rationale is evident and meets all current requirements.

The facility owner and the two clinical managers have a strong commitment to quality improvement and this was reflected in discussions with the clinical manager. The four of four caregivers state they feel valued, supported and are well trained. The service is reviewing ways of demonstrating improved outcomes for residents.

The district health board contract requirements are met.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

Documentation identifies that all residents have the right to communication in a manner that ensures their understanding of service delivery. This is reflected in the open disclosure and interpreter policies. Open disclosure policy identifies the services commitment to the provision of safe, quality healthcare to the residents and the community it serves. Information is provided to the resident and/or family/whanau in a timely, open honest manner as confirmed in interviews with three of three registered nurses and four of four caregivers.

All bedrooms in the dementia unit are single rooms with the exception of two double rooms. Residents interviewed state that service providers have sufficient time for discussions and appropriate space for discussions is available and they are given time to talk about the care they are receiving. Staff wear name badges and it was noted that staff always introduced themselves and visitors to residents on the day of the audit.

Interpreter policies and procedures detailing access to interpreter services is available. Interpreters are usually accessed through the DHB if required. There are no residents currently requiring the use of an interpreter.

The district health board contract requirements are met.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA

Evidence:

Policy is in place to ensure all residents are aware of treatment and interventions planned for them. Processes allow the resident to make their wishes, requirements and expectations known to service providers. Residents' rights to make decisions related to their care is provided by management and explained as part of the pre-admission and admission procedures. A copy of the Code is provided in the information and is given to residents/family/whanau prior to specific consent forms being signed.

The clinical nurse managers and registered nurses interviewed demonstrate a good understanding in relation to informed consent and informed consent processes. Training is provided and is documented in the education programme (sighted). Three of three residents interviewed in the rest home confirm they have been made aware of and understand the informed consent process and that appropriate information has been provided. The GP interviewed clearly understands and has input into processes in relation to advance directives and advance care planning.

Informed consent is obtained for consent for health information to be released, provided to other health care services and government bodies, access for surveys and certification audits, and storage of records is in accordance with the Health Information and Privacy Code 1994. Additional consent is organised for photography, minor surgery to be performed, transportation for outings to appointments and activities, indemnity purposes, influenza vaccinations annually and for all care services to be provided. Five of five family members at interview are fully informed about informed consent and why consent is obtained as required. Evidence of informed consent forms are retained in the six of six residents' records reviewed. There is only one advance directive in the six records reviewed and this evidences review at the MDT meetings.

The district health board contract requirements are met.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA

Evidence:

Documentation identifies that residents have the right to contact the Nationwide Health and Disability Advocacy Service at any time if they are unhappy with service provision. Residents may choose who they wish to act as an independent advocate on their behalf and those interviewed (three of three in the rest home) confirmed that advocacy support is available if required. There is an independent advocacy service promoted and the pamphlets are in the main hallway of the rest home. Pamphlets are available and the contact details are clearly documented for the Nationwide Health and Disability Advocacy Service.

The seven of seven staff interviewed have received training on the Code inclusive of advocacy and the importance of a support person.

The district health board requirements are met.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA

Evidence:

Residents are encouraged to maintain links with their family/whanau and the community. Systems are in place to ensure resident safety and well-being is not compromised by the visitors to the service, such as a signing in and out book. The three of three residents in the rest home confirm they can have access to visitors of their choice. One family member from the dementia unit verified that he is able to visit daily and assists at mealtimes. The facility has open visiting hours. Five of five family interviews verified that they can visit anytime and always feel welcomed and valued.

Residents are free to access community services of their choice and the service utilises appropriate community resources. Residents were seen walking to the nearby shopping centre and Café. Residents requiring supervision are taken for walks as able outside the facility.

The district health board contract requirements are met.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)
Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)
The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA

Evidence:

The owner/manager and two clinical nurse managers, registered nurses (RNs) confirm that upon entry to the service complaints management is part of the information that is discussed with the resident and family/whanau. Complaints information is contained in the booklet given to all residents. This is confirmed during five of five family/whanau and three of six resident interviews. Three of the six residents interviewed from the dementia care area could not remember being given this information. Complaint forms are available at the entrance to the rest home area and notices in the dementia care area (the cottage) state where the forms are located and that they can be obtained from nursing staff. The owner/manager said they tried to keep complaints forms on display in the cottage area but residents kept taking them.

Interviews with seven of seven staff (four caregivers, two activities coordinators and the chef) plus four management personnel confirm their understanding and implementation of complaints management to meet policy requirements. All complaints are documented in a complaints register and signed off by the owner/manager and/or the clinical manager when a response is satisfactory to the complainant and all corrective actions have been set in place as appropriate. The service undertakes an annual review and analysis of all complaints to ensure that all issues have been fully addressed and that the corrective actions put in place remain appropriate to improve service delivery.

The complaints register identifies that at the time of audit there are no outstanding complaints. The service has had one complaint which was addressed by the Counties Manukau District Health Board (CMDHB) related to the acceptance of a resident who did not have a correct assessment. Discussions with the owner/manager and one of the clinical managers confirm they now fully understand the requirement to sight all needs assessments prior to acceptance of residents.

The service is waiting for completion of a Coroner's inquest undertaken in August 2014. The preliminary report findings were sighted. This relates to a resident who died within 12 hours of admission from a general hospital.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA

Evidence:

Keringle Park business, quality, risk and management plan documents the mission statement, philosophy, goals and objectives covering all aspects of service delivery. Goals and objectives show how planning occurs under the headings of consumer focus, provision of effective programmes, certification and contractual requirements, quality/risk management and continuous improvement processes, and cover all key components of service delivery. The organisational goals are reviewed annually.

There are clearly set out plans, aims and ambitions for 2014-2015. This describes the plan of action and who is responsible for undertaking or overseeing each task within an identified timeline. When each action is completed it is signed off by a member of the management team. Documentation sighted related to the annual ethnicity planning which is undertaken to ensure there is an appropriate match between residents and staff members to meet residents' needs.

Interviews with six of six residents and five of five family/whanau members confirm that all their needs are met by the service.

For over 16 years the facility owner/managers, a husband and wife team, have both worked within the service. One looks after maintenance, non-clinical purchasing, kitchen staff and processes, and financial matters. The other owner/manager oversees all aspects of non-clinical service provision. They are supported by two clinical managers who are registered nurses (RNs) and they job share. They have worked at the facility for 12 and 13 years respectively. The job descriptions sighted identify the member of management's experience, education, authority, accountability and responsibility for the provision of services.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA

Evidence:

During a temporary absence of the owner/managers, the role is shared by the clinical nurse managers who fully understand and are able to perform all aspects of the role. The clinical nurse managers cover each other for planned leave and sick leave and share the on-call component of the job. This ensures the services are managed in an efficient and effective manner to meet residents' needs. This is confirmed during six of six residents and five of five family/whanau member interviews and by the results sighted for the 2014 resident and family/whanau satisfaction survey.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA

Evidence:

A continued improvement rating has been obtained as the service, having fully attained all criteria in this standard, the service can in addition clearly demonstrate review processes, including analysis and reporting of findings, evidence of actions taken based on those findings that have generated improvements to service provision to enhance resident safety and satisfaction as a result of improvements made.

Keringle Park has documented quality and risk management systems which cover all key components of service delivery, such as restraint, health and safety, infection control, adverse event reporting and complaints management.

All policies sighted are up to date and personalised to the service. Two off-site providers assist with policy and procedure oversight to ensure all current good practice and legislative requirements are met.

The organisation ensures compliance of the quality and risk management processes. Regular audits are undertaken and corrective action planning is clearly documented for any deficits found. Data is collected, trended, evaluated for all key components of service (complaints, incidents and accidents, hazards, health and safety, restraint, and infection control). This information is shared with staff and residents appropriately as confirmed in meeting minutes sighted. Staff, residents and family/whanau report they understand and are kept well informed of all quality measures and corrective actions that are put in place. One instance given related to resident laundry not always being put away correctly. This was identified in both the resident and family/whanau satisfaction survey results. All corrective actions were notified to residents and family/whanau and additional feedback was sought. On the day of audit no concerns were raised during interviews. One family/whanau member confirmed that laundry services were greatly improved and that less mistakes in the return of resident laundry occurred.

Annual reviews are undertaken for all areas from which quality data is collected and a report identifies the effectiveness of corrective actions put in place. This information helps inform the business and quality plans. All documented quality processes are implemented by the service to enhance the quality and safety of services provided. Staff, resident and family/whanau interviews confirm any concerns they have are addressed by management.

Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirm during interview that they understand and implement documented hazard identification processes. This is supported by the fact that the service holds tertiary level Workplace Safety Management Practices (WSMP) status awarded by the Accident Compensation Corporation (ACC).

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: CI

Evidence:

Quality improvement data is analysed in a systematic manner which is fully documented to allow a good audit trail of evidence which is easy to locate. The service can demonstrate that they actively seek opportunities for improvement by the analysis of information they gather. Examples sighted relate to clinical service provision and the employment of two additional RNs so that succession planning can occur should either of the senior RNs move on; audit results showing that there was no set process to identify when oxygen tubing is changed so a process was documented and implemented; the running log of incidents or accidents in each residents folder is analysed to identify how improvements can be made and then reviewed and measured to ensure an improvement has occurred for residents. (For example, this is evidenced in the manner urinary tract infections have been reduced over the period of one year from an average of 2 per 1000 bed days to 1 per 1000 bed days). All actions taken are clearly documented and results recorded, graphed and shared with staff.

Issues from all audits are followed up via the use of corrective action planning. The service also belongs to an off-site benchmarking programme which identifies where they sit in conjunction with other like type services in relation to clinical issue,s such as infection control, falls and wounds. This data indicates they sit below the accepted level for other like type services.

Finding:

Quality improvement data is collected for all aspects of the service. Staff meeting minutes and staff interviews confirms they are consulted, have input into and are kept fully informed of all processes. Residents are informed of any changes to be made to services and this is discussed at two monthly resident meetings. A continued improvement rating has been obtained as the service, having fully attained this criterion can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision and resident safety and satisfaction as a result of the review process.

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: CI

Evidence:

Corrective action plans are completed to a level which shows the satisfaction or safety aspect of the expected outcome for residents, visitors or staff. Goals are measurable and progress of the action taken is often supported by pictorial evidence. Some examples include the response made from the 2013 resident satisfaction survey and comments made during resident meetings related to laundry going missing or being place in the wrong resident's room. Separate laundry delivery baskets were purchased, individually named, and located in each laundry area to make it easier for staff to keep residents' laundry together. This has resulted in residents voicing their satisfaction with better laundry services being provided. The environmental audit identified that the storage of emergency water was taking a lot of space, new outdoor approved water collection tanks have been put in place to ensure all best practice standards are met. The service can evidence that if a medication error occurs the nurse responsible is required to redo their medication competency, undertake further safe medication education and is closely monitored for a period of time following the incident. If a second like incident occurs the staff member is stood down from medicine management administration until the clinical managers are sure they can provide a safe service to residents. Staff, resident and family/whanau interviews confirm they feel included and informed of all new process put in place and that the service is very responsive to ensuring resident and staff safety. This is supported by the Accident Compensation Corporation (ACC) which has awarded the service tertiary level Workplace Safety Management Practices (WSMP) status.

Finding:

A review of 2014 corrective action plans identify that all areas where a deficit is found has a corrective action placed around it which is documented to show what action is to be taken to correct this, who is to be responsible for ensuring the action is completed and a completion date. All corrective actions are reviewed and signed off by management when completed. Once the corrective action has been in place for a set period of time it is reviewed to ensure it is working to the advancement of the services being delivered.

A continued improvement rating has been obtained as the service, having fully attained this criterion can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision and resident safety and satisfaction as a result of the review process.

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA

Evidence:

Policy identifies that all adverse, unplanned or untoward events are systematically recorded on specific forms and information is used for an opportunity for service improvement. The open disclosure policy identifies that information about an event must be given to the resident and/or support person in a timely, open and honest manner.

The owner/managers and both clinical managers verbalised their understanding of their statutory obligation in relation to essential notification reporting. Policy identifies who needs to be reported to depending on the issue. For example outbreaks are reported to the Medical Officer of Health. Documentation sighted identifies that all serious events, such as fractures, are reported to Worksafe. Each resident's file has a running log to show any adverse events or incidents that have occurred. Data is collated and trended against previously collected data and used to identify opportunities for improvement as appropriate

All incidents and accidents are recorded on a specific form. Documentation on incident and accidents forms and in six of six residents' progress notes indicates family/whanau are always informed of all incidents, accidents, adverse events or concerns. Five of five family/whanau interviews confirm this and state they are extremely happy with the level of communication between themselves and staff at the facility.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA

Evidence:

Staff who require professional qualifications have them validated as part of the employment process and ongoing annually. Annual practising certificates are sighted for four RNs, the dietitian, podiatrist, physiotherapist, five GPs, nine pharmacists and the pharmacy. All but one recently employed caregiver hold recognised aged care qualifications including dementia care (ACE).

Policies and procedures implemented identify that good employment practice and legislative requirements are met. This is confirmed in a review of seven of seven staff files (one chef, two RNs including the infection control coordinator, two caregivers (one recently employed and one senior caregiver), one clinical nurse manager and one owner/manager). Signed job descriptions and employment contacts are sighted in all files.

There is a comprehensive orientation programme in place with specific competencies for related roles as sighted in file reviews. Staff ongoing education covers all areas of service provision and is clearly documented under each staff member's name. There is an annual in-service education calendar in place and the service actively works to offer staff off-site education related to the role they undertake. Education includes food safety, safe chemical handling,

emergency and fire evacuation education, infection control, challenging behaviour, health and safety, safe medicine management and falls prevention. This is confirmed during seven of seven staff interviews.

Staff appraisals are up to date and staff are required to hold current first aid certificates and this is monitored by the clinical nurse manager. An annual staff review is undertaken to ensure that the staff employed are a good match for the ethnicity identified by residents. This assists the service to ensure all residents' needs can be met.

Interviews with six of six residents (three rest home and three dementia care) and five of five family/whanau members and the 2014 satisfaction survey results identify residents' needs are met by the service. No negative comments were voiced on the days of audit.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

The clinical managers are responsible to ensure that each shift is filled by a staff member with the appropriate experience and skills. Staffing levels reflect residents' assessed needs and all staff who work in the secure dementia area hold appropriate qualifications. As sighted in documentation, a six monthly analysis and review of staffing levels informs staffing planning to ensure the rationale stated is appropriate to meet the needs of the resident.

A review of the rosters for six weeks identifies that staff are replaced for sick leave and annual leave as appropriate. If for some reason a resident's condition deteriorates and requires additional care whilst waiting for re-assessment staff interviews confirm additional staff are put on duty.

Caregivers undertake the cleaning and laundry duties. This is identified in the job descriptions sighted. Staff confirm that they have enough time on all shifts to meet residents' needs. Staff did say that they sometimes do not have time to complete the laundry tasks but that they have had discussions with the owner/manager who has told them that residents always come first.

The facility has three separate buildings on the grounds. One area known as 'the lodge' houses up to four rest home care residents who are usually under the age of 65 years but are able to perform activities of daily living independently or with minimal assistance. Another dwelling known as 'the house' has up to 17 rest home level care residents. The third area is known as 'the cottage' is the secure dementia care area for up to 12 residents. There are dedicated staff who work in this area.

As there is only one caregiver on at night to look after the house and the lodge there is a system in place to ensure staff safety. They carry a portable telephone, there is a LED outdoor light which lights the pathway and the staff member in the cottage is alerted and looks out of the window to watch the other staff member go from one dwelling to the other. Staff confirm they feel safe at all times.

There are two activities coordinators who work 10.5 hours per week jointly. There is a RN on duty seven days a week either on a morning or afternoon shift. Dedicated kitchen staff work seven hours per day.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA

Evidence:

Policy identifies that accurate information is entered upon a resident's admission. Progress notes are updated at least daily. The use of resident unique identifiers, storage of information and the length of time information is stored, shows that the organisation meets current legislative requirements. The six of six residents' record (three rest home, two dementia and one lodge) are integrated and all relevant clinical records of the GP or other health professional attendance is maintained in the records. All records are dated, recorded and signed off appropriately with designations of staff making the entry into the individual records. All support and care needs are clearly documented and the progress records are documented each shift. The clinical nurse managers are aware of confidentiality and the records are stored in the nurses` station/office in the rest home and in the nurse office in a locked cupboard in the dementia unit. The GP interviewed is fully aware of the responsibilities for ensuring the medical records are accurate and up to date and reviews are documented at the time they are completed.

The district health board contract requirements are met.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)
All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)
All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.3: Continuum of Service Delivery

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.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA

Evidence:

The transition, exit, discharge or transfer policy sets out the processes for entry to the service and ongoing management to ensure if a resident's circumstances change appropriate services and transfer occurs. Entry to service is managed by the clinical managers who ensures residents firstly meet the entry criteria to this facility. The admission process is facilitated in a competent, equitable, timely and respectful manner. The admission agreements reviewed defines the scope of service and includes the contractual requirements. A documented nursing assessment process was reviewed. The owner and the clinical manger interviews (two of two) confirm access and entry processes are followed. The service provides rest home and stage 3 dementia services. The services operate twenty four hours a day and seven days a week as stated in the information booklet which is available to all prospective residents and their families (sighted).

The entry screening process is clearly understood by the needs assessment service co-ordinators (NASC) at Counties Manakau District Health Board (CMDHB), Taikura Trust and mental health services for older persons. Authorisation information for entry to this service is evident in the six of six records reviewed.

The district health board contract requirements are met.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days):	*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

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.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

Documentation identifies that all residents admitted to Keringle Park are appropriately assessed by an approved assessment agency. Application for entry is declined if this process has not been completed. The scope of the services provided is identified. The appropriate approval forms are documented in all six of six records reviewed (three rest home, two dementia unit, one lodge). The service register is maintained and all details are entered. A form is completed and should a resident be declined an entry is made to this effect and the reason why they are declined. The two of two clinical managers interviewed confirm access and entry processes are followed.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk:	FA
Evidence:	
Finding:	
Corrective Action:	
Timeframe (days):	*(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

Policy documentation related to care plans identifies that each stage of service provision (assessment, planning, provision, evaluation and review) is undertaken by a suitably qualified registered nurse (RN). Long term care plans are put in place by the second week of admission. Short term care plans are used for unpredicted problems, such as a fracture, infections or weight loss. Advice and input is sought from external disciplines if appropriate and necessary.

Staff training records detail appropriate qualifications and/or experience and staff interviewed (two clinical managers) confirm they are trained and competent. There are two other registered nurses employed. All registered nurses have current annual practising certificates (APCs) and this is able to be verified. The APCs of other health professional, such as the GPs, pharmacist, podiatrist and physiotherapist, are also maintained and a record retained by the clinical manager.

The residents (four of six, as two are in the dementia unit) and five of five family interviewed, confirm their input into the care plan. The four of four care staff, in their view, when interviewed, are competent to perform expected tasks. All staff working in the dementia unit are fully trained in dementia care and this is evidenced in the training records and personal files reviewed. The job descriptions sighted define the responsibilities of the roles.

The registered nurses develop the care plans in discussion with the resident and family to ensure all the needs can be effectively identified. Six of six residents' records are available for review. The interRAI assessment performed by the NASC service or other services is used as the basis for developing the long term care plan for each individual resident.

The staff interviewed encourage and promote, a team approach to service delivery and continuity of care for the residents in the rest home and the dementia unit. Care plans are reviewed by the registered nurses six monthly or more often if necessary. Activities goals are reviewed monthly.

The GP confirms at interview that staff inform the GP of any resident's medical issues and concerns in a timely manner. The GP prescribed treatments are followed by staff and any change in the residents` conditions is reported to the GP. Interviews with five of five family and the three residents in the rest home confirms their satisfaction with this service and service provided.

The district health board contract requirements are met.

Tracer Methodology Rest Home:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer Methodology Dementia Unit:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: FA

Evidence:

Policy identifies assessments are undertaken by a registered nurse. There are four registered nurses employed, two of whom share the clinical manager position. All preferences likes and dislikes are taken into consideration and, with consent of the resident, the family are involved to ascertain all relevant details, inclusive of the social and medical history for an effective assessment. The registered nurses interviewed state they have all resources readily available to make assessments of the residents in their care. Scales, sphygmonometers, stethoscopes, thermometers were available. Assessment record sheets are available for the comprehensive initial assessment and recognised tools are also available. Assessments sighted include pain, elimination, Coombes fall risk, oral and Norton scale for skin integrity assessment. The two clinical managers have been fully interRAI trained. The interRAI NASC assessment is always referred to for care plan development and during the review process. The six of six residents' records randomly sampled include the required assessments. The six monthly care plan reviews are recorded on the care plans. The activities assessments six monthly are completed at the same time.

The district health board contract requirements are met.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: FA

Evidence:

Policy states that residents' care plans will identify goals and expected outcomes related to what the resident wishes to achieve. The six of six residents' records reviewed evidence the care plans are up to date. The long term and short term goas are identified by the residents with input from family/whanau and are reviewed at regular times, at least six monthly or as needs change. Goals are individualised and up to date. Residents, if possible, do have input into their care plans. A schedule is available of when the care plans are due to be reviewed and by which registered nurse.

Three of three rest home, two dementia unit and one lodge care plans reviewed evidenced problems/needs being identified. Interventions are clearly documented so as to achieve the set goals documented. The service encourages a holistic approach to care and all aspects of service delivery.

The residents' care plans are integrated (in six of six sighted). The individual resident's records reviewed have ten sections for storing the information required, such as contact information, medical and nursing clinical records, needs assessment and service agreements, referral agencies and communication with other health providers and outpatient clinics, laboratory results, radiology, assessment tools utilised for the individual residents, monitoring forms, vital sign records and other relevant information.

The district health board contract requirements are met.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)
Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)
Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA

Evidence:

Six of six care plans reviewed evidenced interventions that are consistent with, and which contribute to, meeting the assessed needs identified during the comprehensive assessment process on admission or when the care plans are reviewed six monthly or earlier if required. The direct support or intervention by the registered nurses are documented and record the required encouragement, direction, or supervision of a resident completing an intervention themselves.

Staff utilise written progress notes to record any resident's issues. The GP documentation and records are current (sighted). Visual inspection evidences adequate continence supplies and dressing supplies in accordance with requirements of the service agreement. Five of five family interviewed confirm current care and treatments meet the needs of their family member receiving care. The family communication record sheets at the front of each resident's file reviewed demonstrate that consultation and liaison has occurred with family/whanau. Staff also utilise a communication book and handover is provided between each shift.

The district health board contract requirements are met.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: FA

Evidence:

The activities programme is developed and implemented. The activities are developed for the rest home and dementia unit to maintain the resident`s independence, strengths and reflect ordinary patterns of life. Family/whanau are welcome to participate and support the residents. The programme is suitable and interesting and some activities involve community groups or outings for the residents into the community. The residents are regularly taken for walks outside in the rest home grounds. The gardens within the secure dementia unit grounds has lots of colour and concrete ornaments, such as rabbits, pigs, sheep are enjoyed by the residents.

There are two activities persons. One activities co-ordinator has been in this role for 17 years and the other for eight years. Training has been attended over those years and is recorded in the individual staff records. Ten and a half hours a week is provided for activities and staff assist with activities at other times of the day. The activities plans are reviewed and signed off by the clinical manager on a regular basis. The activities in the rest home were sighted and the residents interviewed (three of three) enjoy this each day. Residents have a choice of attending or not. An attendance record is maintained by the activities co-ordinators.

Transportation is organised for external activities. Volunteers assist when required. Community groups are welcome to come to this facility as part of the activities programme.

The residents in the dementia unit are receiving activities a few hours at a time. Activities such as music sessions, walks in the garden and staff involvement and participation in various activities is what residents enjoy.

The district health board contract requirements are met.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

Policy identifies that care plans are reviewed at no less than once every six months. Policy states that evaluation is the measurement of success in meeting set goals and objectives. If these are not met then the care plan is modified. Input may be obtained from the GP, occupational therapist, diversional therapist, physiotherapist during the review process. The multi-disciplinary team (MDT) meetings are held six monthly and this is evidenced in the six of six residents' records reviewed. The care plans are updated if any significant changes occur. The progress records are evaluated each shift and at each point of contact with the residents.

The GP confirms at interview that staff contact the GP if there is any change in the resident`s condition. When progress is different than expected the family with consent of the resident are contacted.

The district health board contract requirements are met.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

Documentation identifies that a referral will be made to other health services as required. Resident safety is paramount and all staff are aware of their responsibilities in conjunction with the general practitioners if a resident requires a referral or subsequent transfer to secondary care or tertiary care (CMDHB).

Referral processes are well documented to guide staff. A record of each stage of a transfer is clearly documented in the individual resident's record. The `yellow bag system` is used if a resident is transferring to Middlemore Hospital or Auckland Hospital. Reasons for the transfer are documented and recorded in the resident's register. If a resident wishes to change rest homes a referral to the NASC service is required. The resident would be supported for the transfer if required and information provided with consent of the resident to the referred service.

The district health board contract requirements are met.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

All aspects of transition, exit, discharge and transfer are set out in policy and procedures. Each stage is communicated to the resident and/or family/whanau. For any discharges, exit or transfer from the service risks are minimised. Safety is promoted at all times with effective discharge planning. The discharge process and record keeping is appropriate for the services provided. Respect is acknowledged and met when a resident deceases. Family are informed as soon as possible. This was confirmed by the five of five family at interview. The communication family record and progress records are updated.

The district health board contract requirements are met.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: FA

Evidence:

Policies in place describe a safe medicines management system to meet legislative requirements. A flow chart is also available to guide staff. The medication policy states that only staff who are competent may administer medication. Policy states that all medication is stored in a secure area. There is policy related to residents who wish to self-medicate which includes a process of assessment to show that the resident is capable to do this. Two residents use inhalers only and have authority to self-medicate from the GP.

The staff responsible for medication management have current medication competencies and attend in-service education for medication management. A visual inspection of the medication systems evidence compliance with respective legislation, regulations and guidelines (medications care guides for residential aged care). The robotic system is used and is effective and safe. This system was implemented two years ago. The medication trollies used in the

dementia service and rest home are locked when not use. The medication fridge is monitored daily. There are no controlled drugs on site for either service. There is evidence of pharmacy input six monthly and audits were performed of all medications in January and May 2014. The pharmacists' APCs are recorded and the contracted pharmacy licence was sighted which expires 23 October 2014. There is a GP and nursing verification signature list in the front of the medication record folders for each service.

Resident individual medication records (12 in total (six dementia and 6 rest home)) are reviewed. All have photographic identification for each individual resident. The rest home photographs were updated 9 September 2014. Any allergies or sensitivities are documented and highlighted to alert staff.

There is evidence of the GPs reviewing the medication three monthly or more often if required. There is a system in place should there be a medication incident or an error occurs. These would be investigated accordingly and outcomes fed back to the staff responsible. The GP interviewed states there is excellent communication with the clinical managers and with the contracted pharmacy if required.

The lunchtime medication rounds in the rest home and dementia services was witnessed and these were managed professionally.

The district health board contract requirements are met.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

Policy identifies that the service offers a nutritionally balanced diet for residents using a cyclic four weekly summer/winter menu. The menus have been reviewed by a qualified dietitian and the annual practising certificate (APC) is available which expires 31 March 2015. The reviews are next to be done 2015 as documented. The last food service audit was performed August 2014. The audit tool used is appropriate for aged care.

Resident's nutritional and fluid needs are identified as part of the admission process by a dietary assessment undertaken by a RN. If a resident has a weight loss then dietitian input is gained on a referral basis as required. The dietitian has regular input and follows all residents on special diets and those on weight gain and weight loss programmes.

Policy clearly identifies that food storage and preparation is undertaken according to safe food practices and guidelines for older people.

The registered chef is qualified and very experienced. At interview the chef is well informed about the food service and meeting the needs of the residents. The clinical manager reports any changes to the chef or if residents are unwell and the meals are planned appropriately. Fluids are provided with each meal, morning and afternoon tea and supper is provided. Residents are routinely weighed monthly or as required. Copies of all dietary requirements for each resident are updated and provided to the kitchen staff for reference. Any special diets, likes and dislikes are addressed appropriately.

The owner is responsible for the ordering of the food and supplies required for the kitchen. Bread and milk is delivered regularly to the facility. Food storage is appropriate and managed well for the size of the facility and services provided. The food service meets the needs of the residents and dining areas are set up in each area of service. Staff are seen assisting residents as needed. Some family members are present in the dementia service to help at the meal time. The meals are well presented and this is verified with the five of five family and four of four residents interviewed. All report satisfaction with the meals provided.

The four fridges are closely monitored and the one freezer by the chef and records are able to be sighted. There is a walk in fridge and all food is stored as required.

All staff working in the food service area are trained in food safety and have undertaken training of their choice. The chef interviewed has catering certificates and NZQA Safe food handling education is completed by the chef and kitchen hands. Schedules for cleaning are documented and performed as per the schedule timeliness.

The district health board contract requirements are met.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

Waste management processes are included in infection control policies and procedures. Policy states that all waste is disposed of in accordance with infection control practices in order to minimise the risk of contamination through unnecessary exposure. Staff receive appropriate training related to waste collection, spillage, transport and storage..

Chemicals are purchased form the supermarket and kept in their original bottles. All chemicals are securely stored. Staff have undertaken safe use of chemical training and education. The service uses non-toxic substances for cleaning in the dementia area and for the bathroom areas of all facilities.

Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons and goggles. Interviews with seven of seven staff confirm they can access PPE at any time. Staff are observed wearing disposal gloves and aprons as required.

There is a documented process for the safe use and disposal of sharps. The maintenance/owner takes the sharps boxes off site for disposal by an approved provider.

The service undertakes appropriate storage and disposal of waste, infectious and/or hazardous substances to comply with current legislation. Recyclable products are picked up by the local council; other waste is picked up at least weekly by a private contractor. There are no specific territorial authority requirements related to waste care management.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA

Evidence:

Documentation sighted identifies that all processes are undertaken as required to maintain the service building warrant of fitness. The current warrant of fitness expires on 10 July 2015.

Maintenance is undertaken by both internal maintenance and external contractors as required. This is confirmed in the maintenance documentation sighted. Maintenance is undertaken and overseen by one of the owner/managers.

Electrical safety testing occurred during the month of July 2014 and all electrical equipment sighted has an approved testing tag. Compliance for electrical safety is documented by a registered electrician. Clinical equipment such as oxygen concentrators, nebulisers and sit on weigh scales are tested at least annually or when required. The owner/manager stated this last occurred on the 10 September 2014 and that she was awaiting documented confirmation. Documentation was sighted for some equipment testing in March 2014. All testing is undertaken by an approved provider. There is clearly documented evidence this occurs at least annually.

The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids and walking areas not being cluttered. Regular environmental audits sighted identify that the service actively work to maintaining a safe environment for staff and residents. Refurbishment of areas is an ongoing item and this is evident in the newly refurbished bathrooms and some bedrooms. A staff suggestion of placing a sensor light in the bathrooms for resident use at night time has been implemented with very good success and feedback. (The quality and development nurse manager is monitoring information related to falls to see if this change has help reduce falls numbers).

There are easily accessed appropriate outdoor areas for both rest home and dementia residents. The residents in the secure dementia area have a large garden area that is secure and which they are able to use during the day. Interviews with six of six residents and five of five family/whanau members confirm the environment is suitable to meet their needs. Outdoor areas that are prone to getting slippery have materials in place to prevent slipping. On the day of audit there was a contractor undertaking an outdoor audit for slip and trip areas with a view to replacing any non-slip material as required.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

There are adequate toilet/shower facilities in all three buildings, the cottage which is dementia care, the lodge which is for more independent residents under the age of 65 years and the house rest home area. Some bathroom areas have been refurbished.

Hot water temperatures are monitored and documentation identifies that when the hot water system was replaced in July 2014 and the temperature went over 45oC. It was adjusted and rechecked to ensure it was within safe limits. There are separate staff and visitor toilets.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

Rest Home House - With the exception of one bedroom which has a married couple in it, all other bedrooms are single occupancy. One of the bedrooms which are being occupied by one person is able to be used for a couple if required.

The Cottage – (Secure dementia care) There are three double bedrooms and six single occupancy rooms.

The Lodge- (Under 65 residents) There are four single bedrooms.

All bedroom areas are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet resident's wants and needs and have appropriate areas for resident to place personal belongings. Visual privacy can be achieved in shared bedrooms by use of curtains between the beds.

Interviews with six of six residents and five of five family/whānau members confirm they are happy with their bedrooms.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. Each of the dwellings has lounge and dining areas which are clearly designated. Areas contain comfortable furnishings to meet residents' needs. This is confirmed by resident and family/whānau interviews.

Activities are undertaken in the lounge areas at the house and the cottage.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA

Evidence:

There are manuals in place which contain documented procedures related to laundry and cleaning processes. They were reviewed in August 2014. There are three laundry areas, one in each dwelling. The residents in the Lodge have a laundry available to them, and those who wish to, do their own laundry are able to do so. The rest home and cottage laundries are secured when staff are not in them and chemicals are secured. As observed PPE is readily available and used appropriately during cleaning processes. Chemicals are appropriately labelled and safety data sheets are available. In the secure dementia care unit non-chemical cleaning substances are used to good effect. This includes baking soda and vinegar and lavender oil. Staff monitor the cleanliness of laundry on a daily basis to ensure the processes used are effective.

Chemicals are available to meet outbreak management requirements if required. The service has had no infection control outbreaks since the previous audit.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA

Evidence:

Policy states that resident security is very important and that personal belongings and property is protected. Daily environmental security procedures are documented.

The service has emergency supplies which are checked regularly to ensure all equipment and supplies are within expiry dates. This includes food and water supplies as observed.

The documented emergency plan includes fire, power failure, utilities, gas leaks and water damage/flooding. This information is kept in the emergency box located at the entrance to the facility. The emergency evacuation plan and general principles of evacuation are clearly documented. The service has an approved fire evacuation plan dated September 2001. There have been no changes in the building footprint since this time.

Emergency staff education and training is undertaken at least six monthly and this last occurred on 27 May 2014 by an approved educator and no follow actions were required. Six monthly trial fire evacuations are conducted and times are monitored and report against to the Board. Fire equipment was checked by an approved provider in May 2014. Staff education related to civil defence and security occurred in November 2013 and is an annual ongoing event.

There are CCTV cameras throughout the facilities which are monitored from the managers' office. Staff are required to ensure doors and windows are securely closed at night. This is confirmed during staff interviews. Exterior doors are alarmed at night and each door alarm can be isolated if required.

Call bells are sighted in all residents' bedrooms. When the bell is activated an audible ring occurs and ceiling mounted information identifies which area it is. All calls are electronically recorded. This is a recently installed system. Response times to call bells are monitored by one of owner/managers at least quarterly or sooner if there are any concerns about staff response not being undertaken in an acceptable time frame.

Resident interviews confirm call bells are answered in an acceptable timeframe.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)
Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

All resident areas have at least one opening window and/or door which provide natural light and ventilation. The facility is heated by electricity with a wall mounted heater in each bedroom. There are heat pumps in the lounge areas. The facility was warm and well aired on the days of audit. Residents and family/whānau state that the facility is kept at a suitable temperature throughout the year.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)
Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Policy identifies that Keringle Park is committed to promoting a restraint free environment. This is confirmed in meeting minutes and in the restraint register which is blank. Documentation shows that the use of enablers shall be voluntary and the least restrictive option to meet the needs of residents with the intent of promoting independence, comfort and/or safety.

Staff education is undertaken to ensure staff are aware of all process should restraint be used. Interviews with five of five clinical staff confirm their knowledge and understanding of enabler and restraint processes should they be used. One clinical nurse manager who has been employed at Keringle Park for 12 years confirms she has never used enablers or restraints during her time of employment.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

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.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The authorities and responsibilities of the infection control coordinator shows how this role ensures the environment is managed to assist to minimise the risk of infection to residents, service providers and visitors. The infection control coordinator is required to undertake an annual review of the infection control programme, notify the appropriate authorities when required and to undertake monthly surveillance of infection numbers and implementation of recommendations of quality improvements. Staff and management must be kept fully informed of infection control requirements and data results.

The service infection prevention and control and the management systems are in place and verified during the onsite audit. The documented systems are implemented to minimise the risk of infection to residents, staff and visitors to the services provided. The clinical manager, an experienced registered nurse, explained at interview how the programme is implemented. The service also has membership with a contracted advisory service for infection prevention and control. A reference manual is available in conjunction with the service policy manual for reference for all staff as required. The programme is reviewed annually as part of the quality review process.

Signage is utilised around the facility in the various care settings. The infection prevention and control is closely linked with the health and safety programme, quality and risk management. Should an outbreak occur a letter is available to send to family/whanau. The health and safety newsletter three monthly has infection control updates documented. Additional staff are available if and when an outbreak occurs. No outbreaks have occurred since the last audit.

The district health board contract requirements are met.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control coordinator (ICC) oversees the infection control programme and all staff will report any infections. Policy identifies that staff will maintain their infection control education and describes who to seek advice from as required. This is able to be verified with the education records reviewed. The infection control co-ordinator implements the infection prevention and control programme and organises the education to meet the standard requirements. Infection control flip charts are available in each area of service delivery. The ICC reviews the internal audit as evident in the documentation reviewed. The ICC ensures her knowledge is updated regularly through relevant training. All records are maintained by the ICC. Infection control is included in the staff orientation programme. A training workshop booklet is available. The last infection control training was held on the 28 Aug 2104. The ICC has access to all relevant resident information to undertake surveillance, audits, laboratory screening results \and investigations. The infection control committee is appropriate for the size and nature of this aged care residential service.

The ICC reviews all infection control actions undertaken. External specialist advice on infection prevention and control issues is available, if and when required, from the CMDHB or ADHB infection control nurse specialists, GPs, diagnostic service microbiologist and the Ministry of Health resources as required.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

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.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

Policies and procedures reflect current accepted good practice and meet relevant legislative requirements related to an aged care setting. This includes outbreak management procedures. There has been no infection outbreaks since the last audit. The infection prevention and control policies and procedures are cross referenced to legislative requirements to be met. The ICC ensures the policies and procedures are updated and reviewed two yearly. All requirements of the IC standard are addressed and meet the standard.

The district health board contract requirements are met.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Policy identifies that staff have infection control education as part of the orientation process and ongoing thereafter. This is clearly evident in the education records reviewed. Infection control education is provided at orientation. Residents and family education is undertaken as required. All staff receive on-gong education in infection control with the content of infection control documented as evidence. The number of attendees is also recorded. Infection control education is evaluated.

The five of five staff records reviewed confirm orientation that includes infection prevention and control. The ICC provides most of the in-service education and is a trained educator and is a NZ Nursing Council approved competency assessor and clinical tutor at the Wesley Institute of learning. The ICC has worked for thirteen years at this facility and has managed the IC for this period of time. Staff are encouraged to complete some of the on-line training available through different DHBs and the MoH sites.

The service orientation/induction workbook reviewed covers topics such as cross infection and contamination, safe food preparation, storage and serving, outbreak management and isolation, wound care, sharps an skin repair and standard precautions and standard definitions of infection.

The district health board contract requirements are met.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

Policy clearly defines the process of data collection, collation and analysis for the purpose of characterising risk groups and identifying control strategies and data feedback and to those who need to know. Infection control data is collected on specific infection report forms and results inform the quality and risk planning process. The type of surveillance undertaken is appropriate to the size and complexity of the services provided. Standardised definitions are used for the identification and classification of infection events, indicators and outcomes. Results of surveillance are acted upon if any, evaluated and reported to the clinical manager in a timely manner. Surveillance monitoring is the responsibility of the ICC. This includes audits of the facility, hand hygiene and surveillance of infection control events an infections. There is an infection control data sheet in which all infections are documented on a monthly basis. A monthly report is completed and the information is used for benchmarking purposes every three months. Graphs and summaries are provided and reported back to staff at the staff meetings. The surveillance data and reporting forms sighted indicate that standardised definitions are consistently referred to. Surveillance methodology and processes reviewed including infection reports adequately identify the risk factors and needs of the residents. There is one resident with two identified multi-resistant organisms.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*