

Keringle Park Limited - Keringle Park Residential Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Keringle Park Limited	
Premises audited:	Keringle Park Residential Care	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 17 October 2019	End date: 17 October 2019
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	30	

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Keringle Park Limited – Keringle Park Residential Care provides rest home level care and secure dementia care for up to 33 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, a review of residents' and staff files, observations, and interviews with residents, family members, the owners/manager, staff, and the general practitioner. Feedback from residents and family members was positive about the care and services provided.

The one area requiring improvements from the previous audit related to timeliness of interRAI assessments is now fully attained. There are no new areas identified for improvement from this audit. The management of residents' incontinence is an area of continuous improvement.

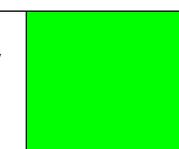
Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service demonstrates residents' rights to full and frank information and open disclosure principles are met. Independent interpreter services are available, and utilised where required.

Complaints management is well documented. All processes are undertaken to meet the standard's requirements. There has been one complaint received in 2019 which has been addressed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation's philosophy, mission and goals statements are identified in the 2019 business and quality and risk management plans. One of the two facility owners is the manager. The manager and the two clinical managers work together to ensure the needs of the residents are being met.

The quality and risk system and processes support effective, timely service delivery. Policies and procedures are developed by an external consultant. The quality management systems includes an internal audit programme, compliments, complaints management, incident/accident reporting, resident/family and staff satisfaction surveys, restraint minimisation, and infection control data collection. Quality and risk management activities and results are shared with the management team and staff. Corrective action planning is documented.

New staff have an orientation relevant to their role. Staff participate in regular and relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and families confirmed during interview that all their needs and wants were met. The service has a documented rationale for staffing which is implemented.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

All standards applicable to this service fully attained with some standards exceeded.

The multidisciplinary team including a registered nurse, diversional therapist and general practitioner assess residents on admission. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Records reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. Activities for the dementia service cover the twenty-four-hour period as required.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents and family verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

The facility has a current building warrant of fitness. There have been no changes required to the fire evacuation plan. Ongoing refurbishment is occurring of residents' bedrooms as they become vacant.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of the use of restraints. No enablers or restraints were in use at the time of audit. Staff interviewed had a knowledge and understanding of Keringle Park Residential Care's restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Aged care specific surveillance is undertaken, data is analysed and results reported and communicated to staff at the staff meeting. Follow-up action is taken when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	16	0	0	0	0	0
Criteria	1	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Keringle Park Residential Care implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family members, the manager and staff reported their understanding of the complaints process and this aligns with the facility's policy. The promoting rights and resolving complaints brochure is readily available in the main entrance along with a 'complaints/suggestions and compliments' form.</p> <p>A complaints register is maintained. One complaint has been received in 2019. This complaint was acknowledged, investigated and responded to appropriately in a timely manner. There have been no complaints from the Ministry of Health, District Health Board or Health and Disability Commissioner since the last audit. Staff interviewed confirmed they would bring any resident or family member's concerns to the attention of the clinical managers/RNs or manager/owner.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. One resident does not speak English. Staff communicate with this resident via use of key phrases in the resident's first language and via nonverbal communication. When the resident is visited by external health professionals from the district health board, an interpreter is used as noted in the resident's file.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>The family members interviewed confirmed that they were kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Communications with family are documented in sampled residents' files.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business, and quality and risk management plans detail the mission, philosophy, values, scope, and goals of the organisation. The service is managed by the manager who is one of the two owners. The two owners have owned this aged care facility since 1998. The manager is responsible for the services provided on site with support of the two clinical managers (CMs), who have both worked in this facility for at least 17 years.</p> <p>The manager has exceeded eight hours of education per annum related to managing an aged related residential care facility as required by the providers contract with Counties Manukau District Health Board (CMDHB). The manager monitored process in achieving goals via the quality and risk programme, resident and family feedback and by being on site at least four days a week including evenings and weekends. The manager and one of the CMs are on call when not on site. The CMs each have allocated responsibilities.</p> <p>There was a total of thirty residents receiving care at the time of audit. The facility has an Aged Related Residential Care Contract (ARRC) with CMDHB for the provision of rest home and dementia care services. There were 23 residents receiving care under this contract. This included thirteen at rest home level care and ten at dementia level of care. A contract is also in place for the provision of Community Residential Respite Services (short term care). There were no residents receiving services under his contract. There is a Residential Non-Aged Contract with the Ministry of Health. There were three residents receiving care under this contract, all at rest home level of care. There is a Long Term Conditions Chronic Health Contract (LTC CHC). Four residents were receiving rest home level care under this contract.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>FA</p>	<p>Keringle Park Residential Care has a quality and risk management system which is understood and implemented by service providers. This included internal audits, satisfaction surveys, incident and accident reporting, health and safety reporting, hazard management, infection control data collection and management, and concerns, compliments and complaints management.</p> <p>Keringle Park Residential Care undertakes an annual resident and family satisfaction survey. The feedback from the relative satisfaction survey conducted in June 2019 was positive about the services provided. A staff satisfaction survey (March 2019) and staff wellness survey (May 2019) have also been completed. The results of these surveys were also positive.</p> <p>Regular internal audits have been conducted, which covered relevant aspects of service including aspects of care, documentation and medicine management. The audit results sampled showed a high level of compliance with the organisation's requirements. If an issue or deficit was found, a corrective action has been put in place to address the</p>

improvement principles.		<p>situation. In addition corrective actions have been developed and implemented in response to a complaint, sampled accidents/incidents, discussions during meetings, and reported maintenance issues. There is monitoring occurring that the actions taken have been effective.</p> <p>Quality information is shared with staff via shift handover as well as via the monthly staff meetings. The minutes of staff meetings are detailed and made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations, policies/procedures, incidents/accidents, restraint minimisation, staff education/training, the results of internal audits/surveys, feedback from residents' meetings, facility/equipment and maintenance activities, and relevant external events including the community based measles outbreak.</p> <p>Quality and risk activities and outcomes have also been discussed at the three monthly 'service review' meetings. Operational and quality and risk issues discussed at this meeting including incident/accident and infection trends, staffing, complaints/compliments, policy and procedure changes, hazards and their controls, the internal audit programme, occupancy, and staff training/education.</p> <p>Regular meetings have been held with residents to obtain resident feedback on food, laundry services, staff and the activities programme. The minutes of three meetings were sighted. Feedback from residents has been discussed at the staff meetings.</p> <p>Policies and procedures have been developed by an external consultant and localised to reflect the needs of Keringle Park Residential Care. All policies and procedures have been recently updated as noted in the staff meetings and service review meetings. The manager advised being in the process of printing the new policy documents for staff. Staff interviewed confirmed they normally have a copy of all policies readily available and have been informed that policy documents have been updated. Requested policies and procedures were sighted during audit.</p> <p>Actual and potential hazards / risks are identified in the hazard register. The hazard register and mitigation strategies have been recently reviewed. The hazard register includes words and pictures to help communicate key messages to staff who have English as a second language. Organisation risks are documented in the quality plan and monitored. The manager described the organisation's risks and ongoing mitigation strategies. Resident specific risks are evaluated during interRAI assessment and care plan reviews.</p> <p>Quality improvement projects have been undertaken. This has included a project related to continence management. This is an area of continuous improvement (refer to 1.3.6.1).</p>
Standard 1.2.4: Adverse Event Reporting	FA	Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Applicable residents' events have been reported in a timely manner. Sampled events have been disclosed with the resident and/or designated next of kin. This was verified by residents and family members interviewed, and records of communications maintained in the sampled residents' files.</p> <p>A review of nine reported events including witnessed and unwitnessed falls with and without injury, a bruise and skin tear, a medication error, episode of challenging behaviour, and a near miss event, demonstrated that incident reports are completed, investigated and responded to in a timely manner.</p> <p>Staff advised they communicate incidents and events to oncoming staff via the shift handover. Events have been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted.</p> <p>The manager advised a total of three essential notifications to the Ministry of Health and/or District Health Board have been made by Keringle Park Residential Care since the last audit. These were in relation to a resident's pressure injury (2018), missing sleeping pills (July 2019), and a resident that was absent without staff knowledge (August 2019). The manager and clinical manager interviewed can detail the other type of events that require reporting. There have been no events that required reporting to the Coroner.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process included completing an application form, interview, referee checks, police vetting, and validation of qualifications and practising certificates (APCs), where required. The job description / employment contract was present in sampled files along with a confidentiality agreement. A sample of staff records reviewed confirmed that policies are being consistently implemented and records retained.</p> <p>All employed and contracted registered health professionals (RHPs) have a current annual practising certificate (APC). Copies of the APCs are on file. The two clinical managers are both registered nurses. The CM that works the most hours has interRAI competency. The other CM is a New Zealand Nursing Council approved assessor and is an assessor for care staff completing industry approved qualifications.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared new staff for their role and responsibilities. Staff records reviewed showed documentation of completed orientation and competency assessment where this was applicable for the role.</p> <p>A staff education programme is in place with in-service education identified and several opportunities and topics are provided every month. Staff have been provided with training on helping residents maintain their oral health. Records of education attendance are maintained.</p> <p>There are 15 caregivers employed. This includes a staff member orientating. Care staff are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are five care staff with a dementia care related qualification. There are currently seven staff who have recently enrolled and are working towards completing a dementia care qualification. All staff working in</p>

		<p>the dementia unit who have been employed 18 months or longer have a dementia level qualification.</p> <p>An annual performance appraisal is required for all staff. These were current in all except one of the seven sampled staff files reviewed. The most recent appraisal noted as completed in the overall staff appraisal summary list was not present in one staff member's file. The CM was unsure where this document was. This is not raised as an area for improvement as it does not reflect a systemic issue. The appraisals in the other six staff files sampled were current, with systems in place to identify when these are next due.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The manager is one of the two business owners and is at the facility at least four days per week (including evenings and weekends). The manager is on call when not on site for non-clinical issues.</p> <p>There are two RNs employed who are both clinical managers. There is one CM onsite weekdays and a CM on call when not on site. The CMs/RNs have worked at Keringle Park Residential Care for between 17 and 18 years each. One of the CMs has current interRAI competency.</p> <p>The roster is for a week period. The two rosters for 7 October to 20 October 2019 were sighted. The roster noted the names of staff covering for unplanned absences or where staff have requested a change in their rostered shift.</p> <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. Staff are rostered to work in either the secure dementia unit or the rest home. Care staff reported there were adequate staff available to complete the work allocated to them, with staff working as a team to ensure the care needs of residents are met. Residents and family members interviewed supported this. All caregivers are employed to work rotating rostered shifts. The care staff undertake laundry and cleaning duties in their allocated areas. Staff working in the secure dementia unit (referred to as the Cottage) have an industry approved qualification in dementia care or are working towards this (refer to 1.2.7). The rest home area is referred to as the 'House' and the 'Lodge'.</p> <p>A cleaner is on site on Sunday for eight hours. There are two cooks who share catering duties seven days a week from 9 am to 3 pm. Activities are facilitated by a diversional therapist or the activities coordinator weekdays (refer to 1.3.7). A physiotherapist comes on Friday at 1.30 and Tai Chi classes occur once a week (Tuesday at 1.30 pm). Time is allocated for maintenance and gardening.</p> <p>There is a staff member rostered on duty with a current first aid certificate, and a staff member rostered on duty in the rest home and secure dementia unit with a current medicine competency.</p> <p>The manager/owner advised there are currently no staff vacancies.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The medication RN coordinator checks all medications against the prescription. All medications sighted were within current use by dates. Pharmacist input is provided six monthly and as required. The GP interviewed stated that he works collaboratively with the pharmacist and the RNs.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register is checked weekly when medications are in use.</p> <p>The records of temperatures for the medicine fridge are maintained. Good prescribing practices and all requirements for pro re nata (PRN) medicines were met. The required three monthly review was consistently recorded on the electronic medicine chart and reviews were verified on the sample of medication records reviewed.</p> <p>There were two residents who were self-administer medications at the time of audit; one using an inhaler and the other a special skin cream. Appropriate processes were in place to ensure this is managed safely.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by two cooks who work four days on and four days off. The food service is provided in line with recognised nutritional guidelines for older people. The menu plans are four weekly and follow summer and winter patterns and have been reviewed by a qualified dietitian within the last two years. Any recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Keringle Park Residential Care has a food control plan registered with the Ministry of Primary Industries (MPI). A verification audit is scheduled to occur on 11 December 2019 as per an email sighted. Food temperatures, including high risk items are monitored appropriately and recorded. The cook interviewed has undertaken relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a nutritional profile is completed. The personal preferences, any special diets and any modified texture requirements are made known to staff and accommodated in the daily menu plan. Residents in the secure dementia unit have access to food and fluids to meet their nutritional needs at all times. Special equipment to meet residents' needs is available.</p> <p>Evidence of food satisfaction with meals was verified by resident and family interviews, satisfaction surveys and the</p>

		resident meeting minutes reviewed. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in both the rest home and the secure dementia unit.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	CI	<p>Documentation, observation and interviews verified that the care provided to residents in the rest home and dementia service was consistent with their needs, goals, interventions and the plan of care. The attention to meeting a diverse range of resident's individual needs was evident. The GP interviewed verified that medical input is sought in a timely manner and that medical orders/instructions are followed, and the care provided is optimum. Care staff confirmed that care was provided as outlined in the care plans. A range of resources was available suited to the level of care provided and in accordance with the residents' needs.</p> <p>Keringle Park Residential Care has developed and implemented strategies to improve the continence program for residents with dementia which are beyond the full attainment rating. This is an area of continuous improvement.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a diversional therapist (DT) and an activities coordinator (18 hours per week). The DT works every Monday and Friday and the coordinator is employed for Tuesday, Wednesday and Thursday. The coordinator interviewed at audit has been at this facility for four years. Activities logs are maintained for all individual residents and copies of the activities programme were reviewed.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan review and multidisciplinary meetings.</p> <p>Activities reflected resident's goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. The programme is displayed in all service areas. Resident and families/whanau are involved in evaluating and improving the programme through residents' activities programme satisfaction surveys last completed June 2019. Residents interviewed confirmed they find the programme interesting and enjoyable. The four rest home residents in the lodge, three of whom are under 65 years of age, enjoy different personalised activities of interest and independence is encouraged and maintained. Special days are arranged for the men specifically and this is enjoyed as evidenced with interviews and photographs displayed. The women were observed having a high tea on the day of audit and this was enjoyed by all participants.</p> <p>Outings in the community are arranged regularly and transport is organised.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. The programme covers the twenty four hour period daily. Resources are available for staff.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the registered nurse.</p> <p>Formal care plans and evaluations occur every six months in conjunction with the six-monthly interRAI reassessments or as residents' needs changed. Where progress is different from expected the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for urinary tract infections, wound care, and skin tears. When necessary and for unresolved problems, the long term care plans are updated. Resident and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There was a current building warrant of fitness (BWF) with an expiry 10 July 2020. There have been no changes to the facility since the last audit except for ongoing maintenance and refurbishment as rooms become available.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The manager advised there have been no changes to the facility that have required a change in the approved fire evacuation plan. Fire evacuation drills are undertaken, most recently on 5th September 2019. Records of attendance are maintained. The emergency plan includes identifying each resident's dependency level in the event of an emergency. There are three categories (dependant, independent and very dependant). This dependency level is noted for each resident in the daily resident attendance register to help guide staff in the event of emergency.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for</p>	FA	<p>A senior registered nurse is the designated infection prevention and control coordinator (IPC) who is responsible for the infection control surveillance and reporting to management any results on a monthly basis. Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue,</p>

<p>infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. The IPC reviews all reported infections, and these were documented. Any new infections and any required management plan are discussed at handover to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of surveillance are shared with staff via the staff meetings and at staff handovers. Graphs are produced that identify any trends by month and comparisons against previous months and years and this is reported at relevant meetings. There have been no outbreaks of infection since February 2017.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures guide staff practices related to restraint minimisation and safe practice and the use of enablers. Staff are provided with training on these topics. There were no residents using restraints or enablers at the time of the audit. Staff interviewed demonstrated understanding of the differences between restraints and enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed</p>	CI	<p>Two registered nurses interviewed developed and implemented a continence program specifically for residents with dementia. This was done in collaboration with care staff and as part of the organisation's quality improvement (person centred toileting plan) programme. Consent was gained from the dementia care residents' family members (7 of 10) to implement the programme. Records were maintained over three weeks by care staff and all incontinence padding was removed from these residents and regular toileting interventions commenced. Routines were soon established. The data evidenced voiding and elimination patterns and from this each resident's person centred plan was established. The programme results were presented by the two RNs 'Dementia with dignity – Aiming for Normal' at the 2018 Counties Manukau Health Nursing and Midwifery Awards – Health of Older People Residential Care forum. The two RNs at Keringle Park Residential Care were acknowledged for their leadership and role modelling best practice as</p>	<p>A continuous improvement rating is made for achievement beyond expected full attainment for the quality improvement initiative implemented to improve incontinence of advanced dementia residents. The results and evaluations of this initiative have been outstanding and four residents of seven (57% success rate) who were previously treated as incontinent are now out of incontinence products and enjoying normality and freedom of using the toilet. Staff are now recognising residents' non-verbal cues when they need to be taken to the toilet and it has been noted that the falls rate in the dementia service over a period of three months was five compared with over 13 over the previous three months. The service has received praise and gratitude from family and have also received a</p>

needs, and desired outcomes.		they led their team through this successful change.	compliment from the DHB. The programme is ongoing.
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End of the report.