

Keringle Park Limited - Keringle Park Residential Care

Introduction

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

The audit has been conducted by 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: 15 February 2022	End date: 16 February 2022
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:	31	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Keringle Park Residential Care provides rest home and secure dementia care for up to 33 residents. The service is operated by Keringle Park Limited. The two owners oversee the day to day management of the facility and are supported by two clinical nurse managers. Residents and families interviewed spoke highly of the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Counties Manakau District Health Board (CMDHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, staff, contracted health providers and a general practitioner.

There were no areas identified as requiring 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 Code of Health and Disability Services Consumer Rights (the Code) is incorporated into the service's policies and procedures, and into everyday practice in the way care and support is provided. Residents who were interviewed advised that they are aware of their rights and can choose what they want to do. They confirmed that there is good communication from staff.


Residents are treated with dignity, respect, and understanding. Privacy is respected and ongoing family involvement is encouraged. Cultural and spiritual values, beliefs, and wishes are identified and supported. There is ongoing contact with the local health and disability service advocate.

Residents can participate in a range of activities, both within the service and in the wider community depending on the national COVID-19 alert levels. They are supported and encouraged to be as independent as possible.

There was no evidence of abuse or neglect, or any discrimination, coercion, harassment, sexual, financial, or other exploitation. Residents and whānau interviewed spoke very positively about the care and support provided.

A complaints register is maintained with complaints resolved promptly and effectively.

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 business, quality and risk management plan includes the scope, direction, mission statement, philosophy, values and a statement of purpose. Monitoring of the services provided is regular and effective. The facility is managed by the manager/owner and two clinical nurse managers. The co-owner is the maintenance manager.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to continuous improvements. The programme is overseen by a contracted quality consultant. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective action plans implemented. Actual and potential

risks, including health and safety risks are identified and mitigated. Policies and procedures support all aspects of service provision and were current and reviewed regularly.

The appointment, orientation and management of staff are based on good practice. A systematic approach and delivery of ongoing education supports safe service delivery. Staffing levels and skill mix meet the changing needs of the residents.

Resident' information is accurately recorded, securely stored and is not accessible to unauthorised people. Archived records can be retrieved as needed. Staff and residents' records are maintained using integrated hard copy and electronic records.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The access to the facility is appropriate and efficiently managed by suitably qualified staff using relevant information provided prior to admission.

The multidisciplinary team, including clinical managers (CMs) and a general practitioner (GP), assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and the needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred 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. A dementia 24-hour care plan is developed for all residents in the dementia unit.

Medicines are safely managed and administered by staff who are competent to do so. Medication reviews are completed every three months or when there is a significant change by the GP.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed and residents verified satisfaction with meals. Nutritional snacks are available for residents 24 hours a day.

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.
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There are processes for managing waste and storage of any chemicals used on site. The building warrant of fitness is current and displayed at the entrance to the facility. Electrical equipment is tested and calibration of all medical equipment occurs as required.

The facilities are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Laundry and cleaning is completed on site. Chemicals, soiled linen and equipment is safely managed. Products used are monitored for effectiveness. The facilities meet the needs of residents and were clean and well maintained. The maintenance manager and the groundsman are responsible for the maintenance of the facilities and the grounds.

Staff are trained in emergency procedures, use of equipment and attend regular fire drill and training sessions. A nurse call bell is in place in all service areas to summon assistance as needed. Security is maintained.

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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There are policies and procedures to guide staff on the use of restraints/enablers and management of challenging behaviours. On the day of the audit no residents were using restraint or enablers. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in restraint minimisation, challenging behaviours and de-escalation techniques.

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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The infection control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator (ICC) is responsible for coordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and are carried out as specified in the infection control programme.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Keringle Park staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). For example, staff were observed knocking on residents' doors before entering their rooms, and staff spoke to residents with respect and dignity, calling residents by their preferred names. The Code is included in staff orientation and the annual in-service education programme.</p> <p>The residents interviewed confirmed that they are treated with respect and understood their rights. The whānau interviewed reported that residents were treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA), where applicable. All residents in the dementia wing had enacted EPOAs in place. Consent forms regarding use of close circuit television cameras (CCTV) for security purposes were signed in residents' files.</p> <p>The GP makes a clinically based decision on resuscitation authorisation in consultation with residents, EPOAs or family/whānau respectively. There are guidelines in the policy for advance</p>

		<p>directives that meet legislative requirements. Advance directives and advance care plans are used to enable residents to choose and make decisions related to end-of-life care. Some files reviewed had signed advance care plans that identify residents' wishes and meet legislative requirements.</p> <p>Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>As part of the admission process, residents and their whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the nationwide advocacy service were displayed and available in the facility. Residents and whānau were aware of the advocacy service, how to access this, and their right to have support persons. The CMs and staff provided examples of the involvement of advocacy services concerning residents' care.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. All residents are assisted in accessing community resources and mainstream support. Whānau and friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' whānau and friends. Restrictions are put in place in response to Ministry of Health COVID-19 protocols. Whānau members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<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>The complaints/compliments policy reviewed meets the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families when the resident is admitted to this service and those interviewed were well informed. Compliments are acknowledged and fed back to staff.</p> <p>The complaints register reviewed demonstrated that two complaints have been received in the last 12 months and that actions were taken through to an agreed resolution and completed within the required timeframes. The two complaints followed through were effectively closed out and signed and dated. Improvements were made where possible.</p> <p>There have been no external complaints received since the last audit. The management of complaints and follow-up is shared between the manager and/or one of the two clinical nurse managers (CNMs). All staff interviewed confirmed a sound knowledge and understanding of the</p>

		complaint process and what actions are required.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their whānau, as confirmed in an interview with the clinical managers (CMs). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally during daily care. Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Residents' agreements signed by either the residents or enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board contract requirements.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There is a policy and procedures regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Staff respect and allow residents to express their personal, gender, sexual, cultural, religious, and spiritual identity. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse and neglect reported since the last audit. Whānau and residents interviewed expressed no concerns regarding neglect or culturally unsafe practice. Staff completed the dementia/abuse and neglect questionnaire on 18 August 2021 and abuse and neglect prevention training on 15 July 2021.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence. There is a contracted physiotherapist who visits the service once a week. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and</p>	FA	<p>Keringle Park acknowledges its responsibilities to Māori residents. The CMs confirmed that the service responds in accordance with the Treaty of Waitangi taking into consideration the Māori Health Strategy and the Māori Health Plan. Cultural safety training was conducted on 12 May 2021. Assessments and care plans document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. Activities and blessings are conducted when and as required. Cultural training for staff is incorporated into the annual in-service education calendar. Five residents identified as Māori and there are two staff members of Māori</p>

cultural, values and beliefs.		descent. One of the staff members was appointed as a Maori cultural advisor. Policies and procedures regarding the recognition of Māori values and beliefs are documented.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner, following protocols/guidelines, as recognised by the resident and their whānau. Values and beliefs are discussed and incorporated into the care plan. Whānau and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in the care plans reviewed.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Whānau interviewed stated that residents were free from any type of discrimination, harassment, or exploitation and that they felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The CMs stated that there has been one incident of abuse reported and this was managed appropriately. No episodes of neglect, nor discrimination towards residents were reported.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies and input from external specialist services and allied health professionals, for example, diabetes nurse specialists, wound care specialists, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support to attend external education and access their professional networks to support contemporary good practice. There is specific training and education to assist the staff to manage residents' safely. The care staff have either level two, three, or four New Zealand Qualification Authority (NZQA) certificates. Five staff in the dementia unit had completed the required dementia training while the other five have commenced dementia training. The activities programme evidenced good practice for residents assessed as requiring the types of care provided.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Whānau members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews This was supported in residents' records sampled. Staff understood the principles of open disclosure, which are supported by policies and procedures. Personal, health, and medical information are collected to facilitate the effective care of residents.</p> <p>Both CMs reported that a variety of external resources, including support groups and interpreter/translation services, are accessed as required. The staff further reiterated that residents and relatives who are not conversant with the English language are advised of the availability of interpreter services at the first point of contact. There were no residents who required the services of an interpreter; however, the staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members, word boards, mobile phones, google applications, and communication cards when required is encouraged.</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, quality risk and management plan was reviewed. The organisation has a mission statement, philosophy, vision and values and a statement of purpose. The business plan is designed to assist the team to achieve the strategies for the business financial year. The annual quality and statistics report sighted for 2021 was reviewed and signed off by the quality consultant, manager and one of the CNMs on the 14 February 2022. The business plan states the objectives and timeframes to achieve the objectives documented. Strengths of the organisation, weaknesses, opportunities and threats are documented and other objectives are documented to achieve if possible.</p> <p>The service is managed by the manager (owner/director) who holds relevant qualifications and has been at this facility for 20 years. The manager is supported by two experienced clinical nurse managers who have worked at the facility for many years; one for twenty years and one for 19 years. All interviewed confirm knowledge of the sector, regulatory and reporting requirements and maintain currency through relevant courses and events related to aged care and other topics of interest. The CNM role is job shared and each have a job description and designated roles they complete, such as infection prevention and control and restraint minimisation and safe practice.</p> <p>The service holds contracts with Counties Manakau District Health Board (CMDHB) for rest home, respite, young persons with a disability (YPD) under 65 years, long term support chronic health care (LTSCHC) and secure dementia care. On the first day of audit there were thirty one (31) residents. This included twenty (20) rest home and eleven (11) secure dementia care residents. There were no residents receiving YPD, respite and/or LTSCHC services.</p>

<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>When the manager is absent, one of the two clinical nurse managers are available to carry out all the required duties under delegated authority. The current system works effectively.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The business risk management policy has been reviewed. Keringle Park has processes in place for the documentation and management of any identified risks, hazards, health and safety, incidents and accidents. The CNM interviewed who is responsible for health and safety was familiar with the Health and Safety at Work Act (2015) and has implemented the requirements. Policies and procedures reflected practices to ensure health and safety requirements are met and staff can access the policies as needed. The outcome approach to risk management is aimed at continuous quality improvement that is resident centred. The risk management register reviewed was current and up-to-date.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings monthly and the three monthly service (management) review meeting. The three monthly service review meeting is a newly implemented quality initiative which is working effectively to address any issues or action items in a timely manner. Residents' meetings are held monthly.</p> <p>Staff reported their involvement in quality and risk management activities through assisting with the internal audit programme. Any issues identified for improvement are actioned immediately.</p> <p>Feedback is sought from residents, staff and families. A staff wellness survey and resident/relatives satisfaction surveys were completed in May and June 2021. Positive feedback was received. Families are kept updated with the monthly circulars/newsletters which are sent out to all families. Family members interviewed stated that they appreciated the updates and felt well informed.</p> <p>There is a document control system which is managed with policies updated by a contracted quality consultant. All policies were updated in 2021. Policies reviewed covered all necessary aspects of service delivery and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Any obsolete documents are removed, archived and can be retrieved if and when needed.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The adverse event policy and procedure is clearly documented to guide staff. The process for reporting and follow-up of any adverse or near miss events was reviewed. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and reported to the manager.</p> <p>The CNM interviewed was fully informed of the statutory obligations for service providers in relation to essential notification reporting. A register is maintained and evidenced that only one Section 31 Notification had been made to HealthCERT since the previous audit. This related to a stage 3 pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures for human resource management and associated documents are in place and can be accessed by management. All policies and processes are based on good employment practice and meet relevant legislation. A selection of staff records were reviewed. The recruitment process included reference checks, police vetting and validation of practising certificates (APCs) where required. Job descriptions were sighted for all roles.</p> <p>Orientation is provided for all new staff and staff interviewed reported that the orientation prepared them well for their role. Performance appraisals are completed at three months post employment and annually thereafter.</p> <p>Training records are maintained and are located in the front of each staff member's individual record. Annual training also includes mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the CMDHB. The CNMs are both internal assessors for the programme. There are 15 care staff employed, nine of whom are senior residential care officers (RCOs - all nine have attained level 4) and six caregivers have attained level 3. One of the six caregivers is currently enrolled in Level 4. Five staff who work in the secure dementia care service have completed the training requirements and five care staff are still completing the training. One caregiver has been appointed the cultural advisor for the organisation and has completed relevant cultural training for this role.</p> <p>One of the two CNMs is fully trained to complete the interRAI assessments and maintains an annual competency. All interRAI assessments were up-to-date with the two most recent assessments currently being completed at the time of the audit.</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>There is a documented rationale covering all service provision at Keringle Park for determining staffing levels and skill mix to provide safe service delivery 24 hours a day, seven days a week. The CNMs adjust staffing levels to meet the needs of the residents and to cover the three facilities. The house provides accommodation for up to 17 rest home residents and the lodge accommodates four rest home level care residents. The cottage (secure dementia care service) provides care for up to 12 residents. An after hours roster is provided with full registered nurse cover (CNMs) 24 hours a day seven days a week. Staff reported that good access to advice is readily available when needed.</p> <p>Residents and family interviewed reported there were adequate staff available to complete the work allocated to them. Observations of a six week roster cycle confirmed adequate staff cover has been provided with staff replaced in any unplanned absence. Staff are trained in first aid and current first aid certificates were sighted in the staff records reviewed.</p> <p>There is a newly employed activities coordinator who is orientating to the role. The activities programme is set up for the rest home and the dementia care service separately. Time is allocated to both care settings. Activities and resources are provided to cover the 24 hour period in the dementia care service.</p> <p>In addition, staff are employed for the kitchen. Cleaning and laundry is completed by the care staff with input of one cleaner who is employed thirty (30) hours a week. There is a groundsperson and the co-owner of the facility is responsible for the maintenance programme. A physiotherapist is contracted and visits one day a week to follow-up individual residents as required. Staff are also contracted, such as a hairdresser and podiatrist.</p> <p>Staff interviewed confirmed they enjoy their roles and most staff have been employed at Keringle Park a long time.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>A resident register of all current and past residents is maintained. Resident's individual information is kept electronically and paper-based. The resident's name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled for review.</p> <p>Records of inquiries that are declined are maintained in a paper record. There was evidence that unsuccessful inquiries are referred to their referrer for alternative providers that may suit their needs.</p> <p>Clinical notes were current and integrated with GP, podiatrist, physiotherapist, pharmacists, and</p>

		<p>other allied health service provider notes.</p> <p>Archived paper records are held securely on-site and are readily retrievable using a cataloguing system. The electronic records are backed up in the 'Cloud-based' system. Residents' files are held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects for the management of inquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the whānau members of choice, where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC) service authorisation forms for the dementia unit, rest home, and hospital level of care residents were sighted.</p> <p>Residents in the dementia unit were admitted with consent from EPOAs and documents sighted verified that EPOAs consented to referrals to specialist services. Files sampled evidenced that all residents were assessed by specialists and confirmed the current level of care.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Whānau interviewed confirmed that they received sufficient information regarding the services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exits or discharges to and from the service, as confirmed in the residents' records reviewed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Keringle Park's medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation.</p> <p>Indications for use are noted for pro re nata (PRN) medications, allergies are indicated, and photos were current. Medication reconciliation is conducted by the CNMs when a resident is transferred back to the service from the hospital or any external appointments. The CNMs check medicines</p>

		<p>against the prescription and these were updated every fortnight or when there were any medication changes. The GP completes three monthly reviews.</p> <p>Medication competencies were completed annually for all staff administering medication.</p> <p>There were no expired or unwanted medicines. Expired medicines are returned to the pharmacy in a timely manner. Monitoring of the medicine fridge and medication room temperatures are conducted regularly and deviations from normal were reported and attended to promptly. Records of this were sighted.</p> <p>The residential care officer was observed administering medications safely and correctly. Medications were stored safely and securely in the trolley and locked treatment room. There was one resident self-administering medication who had been assessed as competent to do so. Medicines were kept in a locked drawer in the resident's room.</p> <p>There were no residents on controlled drugs. Both CNMs reported that controlled drugs are stored securely following requirements and checked by two staff for accuracy when being administered. The controlled drug register was last used in September 2021 and provided evidence of previous weekly and six-monthly stock checks and accurate entries. Outcomes of as-required (PRN) medication were consistently documented.</p> <p>Administration records are maintained, and drug incident forms are completed in the event of any drug 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 kitchen service complies with current food safety legislation and guidelines. The service employs two cooks in the kitchen and caters to 33 residents. One of the cooks works from Monday to Friday while the other cook covers weekends.</p> <p>This food service audit was conducted by reviewing the documentation and records generated through the implementation of the service's food control plan. It included observations, discussions with the cook as to their routine handling practices relating to food safety. There is an approved food control plan for the service which expires in December 2022. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by a registered dietitian on 16 August 2021. The kitchen staff had current food handling certificates.</p> <p>Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.</p>

		<p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers were maintained and these were recorded on the Chomp digital food safety application.</p> <p>The residents and whānau interviewed indicated satisfaction with the food service. Safe food nutrition and hydration training was completed on 7 July 2021.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>The CNMs reported that all potential residents who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person/whanau is referred to the referral agency to ensure they will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI assessments are completed within three weeks, according to policy. Assessments and care plans are detailed and included input from the resident and their whānau and other health team members as appropriate. Additional assessments were completed according to the need (eg, behavioural, nutritional, continence, and skin and pressure risk assessments). The nursing team utilises standardised risk assessment tools on admission. In interviews conducted, whānau and residents expressed satisfaction with the assessment process. Staff had training in falls prevention and moving and handling on 16 June 2021 and fall prevention and implications on 19 November 2021.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The assessment findings and input from residents and/or whānau informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident-focused and individualised. Short-term care plans were used for short-term needs. Residents in the dementia unit had twenty-four-hour behaviour care plans in place. Behaviour management plans were implemented as required. Whānau and residents confirmed they were involved in the care planning process.</p> <p>Residents' files demonstrated service integration and evidence of allied healthcare professionals</p>

		involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapists, district nurses, dietitians, and the GP.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. The CNMs reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person-centred. This was further confirmed by the GP during the interview. Care staff confirmed that care was provided as outlined in the care plan.</p> <p>A range of equipment and resources are available, suited to the levels of care provided and following the residents' needs.</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>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the activities coordinator who has only been a week at the service. The activities are based on assessments and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and areas of enjoyment. Residents' birthdays are celebrated.</p> <p>All residents had a brief introductory remarks in front in each file. A resident's social profile is completed for each resident within two weeks of admission in consultation with the family. The activities staff formulate the activity programme. The activities are varied and appropriate for people living with dementia, rest home level of care, and those under 65 years of age. Residents' activities care plans were evaluated in a timely manner.</p> <p>Dementia twenty-four-hour care plan is developed for each resident in the dementia unit. These reflected residents' preferred activities of choice and were evaluated every six months or as necessary.</p> <p>Activity progress notes and activity attendance checklists are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Whānau members reported overall satisfaction with the level and variety of activities provided.</p>
Standard 1.3.8: Evaluation	FA	Residents' care is documented on each shift by care staff in the progress notes. All noted changes

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>by the health care assistants are reported to the nursing team on time.</p> <p>Six-monthly formal care plan evaluations and interRAI assessments were completed. These measured the degree of a resident's response in relation to desired outcomes and goals. The evaluations are carried out by the CNMs in conjunction with whānau, residents, GP, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan.</p> <p>Short-term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and whānau are included and informed of all changes</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents and whānau are supported to access or seek a referral to other health and disability service providers. If the need for other non-urgent services is indicated or requested, the GP and the nursing team refer to specialist service providers and the DHB. Referrals are followed up regularly by the GP and nursing team. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to, and the resident is transferred to the public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste, infectious and hazardous substances. Appropriate signage was available. Chemicals are stored appropriately and the cleaner, care staff and kitchen staff knew what to do should there be a chemical spill/event. Waste and recycling of rubbish is managed by staff and the council collects all rubbish weekly. Any sharps containers when full are collected by a contracted service provider.</p> <p>The maintenance person and groundsperson have their own lockup garage for their tools and equipment required. There is adequate provision and availability of protective personal equipment (PPE) and clothing and staff were observed using this during the audit. All contractors and visitors sign in on entry to the rest home and are fully screened for COVID-19 to meet infection prevention and control measures in place. Records are maintained.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>A current building warrant of fitness (BWOFF) - expiry 10 July 2022 - is publically displayed. All buildings, plant and equipment comply with legislative requirements.</p> <p>Appropriate systems are in place to ensure the resident's physical environment and facilities are fit</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>for purpose and are well maintained. The maintenance person who reports to the manager was present at the audit. Planned maintenance is ongoing at Keringle Park. Observation of the environment, interviews with staff including maintenance and ground staff verified this does occur. An inventory of all electrical equipment is maintained by the contracted company and this was updated 13 August 2021. Daily maintenance to be completed is signed off and dated when completed. The environment was hazard free, residents in all services were safe and independence is promoted at all times.</p> <p>External areas are also safely maintained and appropriate to the resident groups. There is a secure boundary fence and pathway around the cottage (secure dementia care service). Well established trees provided shade in the garden areas for residents. Some residents have their own garden areas to work in and to maintain their independence. Seating is available inside and in the garden designated areas. Rest home residents were observed having lunch outside in the garden at the time of the audit.</p> <p>Residents and staff confirmed they knew the processes to follow if any repairs or maintenance was required, that their requests are appropriately actioned and that they are happy with the environment. Families interviewed confirmed residents use all areas of the facility available and accessible to them.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>There are a variety of toilet/shower facilities within the facilities in the rest home (house), the lodge and the secure dementia service (cottage). There are no ensuite facilities in any of the three facilities. No room has its own toilet and handbasin. All toilets and showers are in close proximity to residents' rooms.</p> <p>Infection prevention and control signage was observed in the bathrooms and PPE resources are stored outside each bathroom.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote residents' independence.</p> <p>There are separate staff/visitor toilets available in the facility which have key pad access.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move freely if able within their bedrooms safely. In the house (rest home) there are two double rooms. One room has only one resident. Rooms are personalised with photographs, furniture and other personal items being displayed.</p>

<p>appropriate to the consumer group and setting.</p>		<p>There are three shared rooms in the cottage (secure dementia service). Consent is obtained for residents' to share rooms. Privacy is maintained with screening being available between the bed spaces.</p> <p>Mobility aids are arranged by the physiotherapist for any residents to maintain their independence and mobility.</p> <p>Staff, residents and family/EPOA reported the adequacy of the bedrooms and spaces provided.</p> <p>The four residents in the lodge have easy access and are all independent. There is a lounge/dining area/kitchenette/laundry and bathroom for residents to use. Each have their own individual bedroom.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available in all service areas for residents to engage in activities. Each lounge has a television set for residents to access. Lounges are comfortable, relaxing and homely in appearance.</p> <p>There are dining areas with adequate seating arrangements in all service areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There is a designated laundry in all three facilities. Care staff undertake the laundry duties during the day and afternoon shifts. Staff interviewed demonstrated a good knowledge of the laundry processes including dirty/clean flow and handling of any soiled linen. Infection prevention and control principles were clearly understood. There are external washing lines for drying the linen and clothes, especially in the summer months, and electric driers are available if needed. Residents and family interviewed stated that the laundry is managed well and clothes are returned in a timely manner. The staff assist the four residents in the lodge with their laundry; however, residents were seen assisting with hanging out their own laundry and maintaining independence as much as possible.</p> <p>There is a designated cleaner who is employed 30 hours a week. The cleaner interviewed has been in this role for eight months and has received a full orientation and training in chemical management. The sluice rooms, cleaner's room and trollies are stored safely and all chemicals are locked up when not in use.</p> <p>Hand sanitising stations and PPE are set up around the facility for staff to readily access. Care staff also assist with cleaning as needed each day of the week.</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>	<p>FA</p>	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Local council, CMDHB and civil defence planning, guides and directs the facility in their preparation for any disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 17 September 2001. A trial evacuation takes place every six months with a copy sent to the New Zealand Fire Service, the most recent drill being 2 February 2022. This drill included a full training session. The orientation for all new staff includes fire training. All staff completed a fire questionnaire on the 4 August 2021. Staff confirmed their awareness of the fire procedures and the location of any fire safety equipment if and when needed.</p> <p>Adequate supplies for use in the event of a civil defence emergency or other emergency including water, food, blankets, mobile phones and a gas barbecue were available to meet the requirements for the 31 residents and up to 33 if fully occupied. There is a small generator on site which is regularly serviced. Emergency lighting is available and is tested frequently. Emergency water supplies include 240 litres of water in water bottles and there are two large water tanks which meet the requirements as defined by the local council. Packaged frozen moulded food for the dementia residents, dry foods, frozen and canned foods are also readily available. Good emergency food stocks were sighted. A check list of all supplies on hand is available and checks occur as per the internal audit schedule.</p> <p>Call bells alert staff to residents requiring assistance. The display board was visible in the rest home. The call bell system is monitored regularly.</p> <p>Close circuit television cameras (CCTV) for security purposes are installed and signage is available around the facility. The training programme includes annual training which includes security, health and safety and emergency management. Staff check the facilities between shifts.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms in all three facilities are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating in the house (rest home) and cottage (secure dementia service) is provided by a centralised ceiling ducting system (controls area located in the hallways). In addition to this, wall heaters are available in the individual rooms. Wall heaters in the four individual residents' rooms are available in the lodge and a heat pump provides heating for the lounge/dining areas.</p>

<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>Keringle Park has a documented infection prevention and control programme that is reviewed annually. The review of the programme is completed by the CNMs who co-share the ICC role. A position description for the ICC role for both CNMs was in place.</p> <p>The service has guidelines in place to manage and prevent exposure to infections. Infection prevention and control training is provided to staff, residents, and visitors. There were adequate supplies of personal protective equipment (PPE) and hand sanitisers in stock. Hand washing audits were completed as per schedule. Policies and procedures are documented and reviewed regularly. Staff are advised not to attend work if they are unwell or self-isolate and get tested if they have been in contact with a person who has tested positive for COVID-19. Most residents and all staff were vaccinated for COVID-19 and influenza - completed records were sighted in all files sampled.</p> <p>There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. There was a suspected respiratory throat infection outbreak on 14 August 2021 which was managed according to policy. There were seven residents and three staff members affected. There were no confirmed positive cases documented related to the COVID-19 virus. The facility was closed to the public in line with MOH guidelines as Auckland was under COVID-19 national lockdown. Relevant information was shared with the GP, whānau, residents, and relevant authorities notified promptly. Documented evidence of staff and residents affected was sighted.</p> <p>The service undertook an incontinent project in 2017, focussing on rekindling of normal toileting habits in residents with advance dementia. This resulted in reduced urinary tract infections and about 75% residents being able to toilet normally. In 2021 only three urinary tract infections were reported. Keringle Park has continued with the initiative and it is now embedded in their day-to-day practices and culture. The project was recognised in October 2018 by the local district health board. This prompted the facility's clinical managers to be invited to present in Aged Related Residential Care provider forum (ARCC) and consequently at the Health Quality and Safety Commission's Quality Improvement Scientific Symposium in 2018 along with 17 other presenters from the entire healthcare sector. The facility received an award for this project.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	<p>FA</p>	<p>The CNMs are responsible for implementing the infection control programme. The ICCs indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are completed monthly, and these are discussed at management and staff meetings. Staff confirmed that infections rates information is shared in a timely manner. Both ICCs</p>

<p>implement the infection control programme and meet the needs of the organisation.</p>		<p>completed infection control training to keep their knowledge current.</p> <p>The ICCs have access to residents' infection control data collected within the organisation and reported that there are sufficient resources and systems to collect all the necessary information. Surveillance, internal audits, investigations, and corrective actions are completed as required.</p> <p>Specialist support can be accessed through the district health board, the medical laboratory, external consultants, and the attending GP.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The service has documented policies and procedures in place that reflect current best practices. Policies and procedures are accessible and available for staff in all the nurses' stations. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff training on infection prevention and control is provided on an ongoing basis (eg, during orientation, shifts handovers, staff meetings, and in the annual in-service education programme). The in-service education is conducted by either the ICCs, local laboratory, or other external consultants. Monthly infection audits were completed and evidence of this was sighted.</p> <p>The following infection prevention and control education was provided to staff this included introduction to antimicrobial stewardship, outbreak management training, everyday principles of infection, taking the panic out of the pandemic COVID-19, outbreak management competency training, implementation of an infection control coordination role, handwashing procedures, donning and doffing protective equipment, and regular COVID-19 updates. Records of staff education were maintained. The CNMs completed an infection prevention and control training course and evidence of this was provided.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p>	<p>FA</p>	<p>The surveillance programme is defined and appropriate to the size and scope of the service. The ICCs collect infection surveillance data, analyse trends, monitor, review, and where possible</p>

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>implement corrective action plans to prevent recurrences. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings and management meetings. Evidence of completed infection control audits, monthly reports, and annual reports were sighted.</p> <p>All staff interviewed confirmed that they are informed of infection rates as they occur. The GP was informed on time when a resident had an infection and appropriate antibiotics were prescribed for all diagnosed infections.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Keringle Park actively works to minimise restraint and enabler use. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints and enablers. One of the two CNMs is the restraint coordinator and provides support and oversight for restraint management in the facility. The CNM interviewed demonstrated a sound understanding of the organisation's policies, procedures, practice and the role and responsibilities.</p> <p>No restraint has been used since the last audit. The last enabler was discontinued 30 October 2021. On the day of the audit no restraints or enablers were in use. The policy clearly states that use of enablers will be voluntary, and the least restrictive option to meet the resident's needs and promote independence. The interviewed staff understood the difference between an enabler and a restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.