Kerikeri Retirement Village Limited - Kerikeri Retirement Village

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 Health and Disability Auditing New Zealand 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:	Kerikeri Retirement Village Limited
Premises audited:	Kerikeri Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 April 2019 End date: 30 April 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: 65

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

Kerikeri Retirement Village including the care facility is owned and operated by a community trust and governed by a board of trustees. The service provides cares for up to 68 residents requiring hospital, rest home or dementia level of care. On the day of the audit, there were 65 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff, management and a general practitioner.

The service is overseen by a chief executive with a senior management team in place. This includes the clinical manager who provides clinical oversight of the service. They are supported by registered nurses who provide 24-hour, on-site support for residents. Residents and family spoke positively about the service provided.

An improvement is required around annual completion of performance appraisals.

The service is commended for achieving a continued improvement rating around good practice.

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

Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up-to-date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete. Each resident in the dementia unit has an Enduring Power of Attorney (EPOA).

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

There are strategic, business, quality, and risk management plans in place. These define the scope, direction and objectives of the service and the monitoring and reporting processes.

The chief executive with the operations support manager provides operational management of the facility and the clinical manager provides clinical oversight.

There is a documented quality and risk management system in place. There are a range of policies, procedures and forms in use to guide practice. Key components of the quality management system include analysis of data around risks, complaints, incidents, accidents and results from review of goals and surveys. The health and safety and quality risk committee meetings include discussion around data.

The human resource management system is documented in policy with recruitment completed as per policy. There is an implemented orientation and induction programme and an annual training plan implemented.

There is a documented rationale for determining staff levels and staff mix to provide safe service delivery and there are adequate numbers of staff to meet acuity and numbers of residents.

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.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are always available.

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.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness.

There are sufficient ensuites and communal bathrooms. External areas are safe and well maintained with shade and seating available. The dementia unit gardens are fenced. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

Systems and supplies are in place for essential, emergency and security services. Six monthly fire drills are conducted. Appropriate training, information and equipment for responding to emergencies is provided. There is a trained first aider on duty 24 hours.

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.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort with the focus being on reaching a restraint free environment. Staff receive regular education and training on restraint minimisation and around management of challenging behaviour. During the audit there were three residents using restraints and two residents using an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	48	0	1	0	0	0
Criteria	1	99	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented. Staff interviewed, including five caregivers, two registered nurses (RN), one diversional therapist, the cook, maintenance staff, the clinical manager, the chaplain, physiotherapist, operations support manager, chief executive, staff development coordinator, quality and risk manager could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the mandatory component of the staff education and training programme.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (three rest home, three hospital and two dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. In the dementia unit all residents sampled had activated enduring power of attorney (EPOA).

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents and families are provided with a copy of the Code on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrance. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. The chaplain is readily available to residents and families and stated that they advocate for residents frequently. Staff receive education and training on the role of advocacy services. Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files included information on resident's family and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that family and friends can visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. There are many community visitors to the home including volunteers and village residents.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Policy and procedures are in line with Right 10 of the Code and identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints. Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Residents and family confirmed that they are informed by the managers that they can talk with them at any time. Training on the complaints policy and process is part of the staff orientation programme and ongoing education. The complaints register records the complaint, dates and actions taken if resolved. Two complaints reviewed showed that all aspects of the complaints process had been followed. There have not been any complaints lodged by an external authority since the last audit. Complaints forms are available at the main entrance and in the Paterson and Robinson

		corridors.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service has information available on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The Code of Rights (English and Māori) is also displayed in the resident areas. There is a welcome information folder that includes information about the Code of Rights. The resident, family or legal representative can discuss this prior to entry and/or at admission with the clinical manager. Residents and relatives stated they receive enough verbal and written information to be able to make informed choices on matters that affect them. Eight residents (five rest home and three hospital level of care) and four relatives (two hospital level and two dementia level of care) interviewed, confirmed that information has been provided around the Code of Rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff could describe how they maintain resident privacy, including knocking on the resident's doors before entering, as observed on the day of audit. Staff attend privacy and dignity and abuse and neglect in-service as part of their education plan. Care staff interviewed stated they promote independence with daily activities where appropriate. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan to ensure the resident receives services that are acceptable to the resident/relatives. The chaplain provides four hours a week (two mornings) and as required, to provide spiritual support for residents and family. They described a range of interdenominational services provided to residents on a weekly basis with special events such as ANZAC and Easter recognised with services. There is a policy on abuse and neglect. Staff could describe responsibilities around reporting if any abuse or neglect is identified. Staff have received training around abuse and neglect as part of the mandatory training programme. There were no incidents of abuse nor neglect reported in incident forms reviewed nor any documented on the complaints register. Residents, staff and family interviewed confirmed that there is no evidence of abuse or neglect. The general practitioner (GP) and chaplain interviewed confirmed that there was no evidence of abuse or neglect. There are quiet, low stimulus areas that provide privacy for residents in the dementia unit. The

		dementia unit was calm with residents observed to be supported well on audit days. The service is bringing in Spark of Life that also encourages staff to engage respectfully and, in a manner that has regard for dignity of the resident.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to Māori providers and interpreter services. The Māori health plan identifies the importance of family/whānau. Cultural assessment plan and evaluations of care for Māori are completed for those who identify with Māori. A senior staff member is the cultural advisor for the service. There are links to Ngati Rehia. There were residents who identify as Māori on the day of audit. Māori staff interviewed, confirmed that they can converse in Māori and that they believe that resident values are upheld.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six-monthly to ensure the resident's individual culture, values and beliefs are being met. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular church services in the on-site chapel. The service has an ordained lay Minister/spiritual advisor who has 25 years' experience in aged care as a diversional therapist. They visit each resident on the days they are in to ask if the resident requires any cultural or spiritual support and to just 'be' with a resident.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process meets best practice about recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the caregiver role and responsibilities. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Care staff could describe how they build a supportive relationship with each resident. Residents interviewed stated that they are treated fairly and with respect.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The management are committed to providing a service of a high standard, based on the provider vision, mission and values. This was observed during the day with the staff demonstrating a caring and respectful attitude to the residents. All residents and families spoke positively about the care provided. The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Care staff and registered nurses (RNs) have access to training that meets their needs. It also provides staff with opportunities to extend their knowledge. Staff have a sound understanding of principles of aged care and stated they are supported by management. Regular facility and clinical meetings and shift handovers enhance communication between the teams and provide consistency of care. Members of the multidisciplinary team can provide input and support for both staff and residents when required. There is evidence of a responsive and innovative approach to service delivery. A rating of continuous improvement has been given to recognise the service's continuing work to improve systems and processes for the benefit of residents and others.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Management promotes an open-door policy. Relatives/residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Residents can feedback on service delivery through resident meetings and annual surveys. Results and areas for improvement are discussed at resident meetings (sighted in minutes). Residents and relatives receive quarterly newsletters. Family have input into service delivery through six monthly round table meetings and Family/Staff Focus Group meetings and all interviewed stated that there is an open-door policy. Accident/incident forms reviewed document that relatives have been notified of the incident. Relatives interviewed stated they are notified promptly of any changes to resident's health status. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Interpreting services are available if required. Currently there are interpreting services for the deaf used in the service. Staff also use a variety of other strategies to encourage residents who are deaf to engage and communicate (eg, through a white board in the bedroom, sign language booklets and cards with key words). Cards and key phrases are also used for another resident in the dementia unit who has English as a second language. Staff working in the dementia unit

		described using body language and gestures to support oral language for residents in the dementia unit when they have difficulty communicating. Staff also described and were observed to use simple language and giving simple choices for residents who have dementia.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Kerikeri Care Facility and Village has a charitable trust status and is governed by trustees, board members with sub-committees to monitor quality and risk. The board members have a range of expertise to support the chief executive and management team including business management; two clinical members; a representative nominated by the 50% shareholder and members with financial acumen. The chief executive reports to the board at the two monthly meetings with an interim financial report submitted. A service vision, mission and values are documented with staff reminded of these at monthly meetings. The service can provide care for up to 68 residents. There are 23 rest home beds (this includes two double rooms that are currently single occupancy), 26 hospital beds, four dual-purpose beds and 15 beds in a secure dementia unit. On the day of audit there were 20 rest home residents, 30 hospital residents (including two residents using respite services) and 15 residents in the dementia unit (including one resident using respite services). The chief executive (CE) has been in the non-clinical role since July 2016 and has held senior management roles in the community sector. The CE has a Master of Arts degree and has held roles in the community as CE and previous senior management roles with over 15 years' experience in governance roles. They are supported by an operations support manager with experience in human resources, information technology, corporate services and administration. The clinical manager was appointed to the role nine months ago and has had previous experience as a clinical manager in aged care at another facility for over six years. They are supported by an assistant clinical manager, quality risk coordinator and staff development coordinator. All are registered nurses with current practising certificates. The management structure has streamlined the business and clinical effectiveness and reporting channels. There is a 2019 – 2022 strategic plan with an annual business plan in place. There are other plans including a Māori Health plan, quality plan and health and safety plan documented. All plans are reviewed at the end of the financial year and at meetings as relevant to the plan. Key performance indicators and progress against plans are reviewed by board members at two monthly meetings and through relevant meetings such as the monthly quality risk meetings and health and safety meetings. All managers have exceeded eight hours annually of professional development including

		leadership courses and attendance at relevant conferences.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During the temporary absence of the CEO, the village manager provides interim overall management with support from the operations support manager and other members of the senior management team. The clinical manager provides clinical oversight of the facility and the assistant clinical manager provides cover for the clinical manager. A current practising certificate for the clinical manager and assistant clinical manager were sighted. All interviewed were aware of their roles with delegation of roles documented. The CEO when on leave, provides the managers with a detailed summary of key tasks and levels of escalation. A delegation of authority is documented.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The service has a quality risk management plan in place that is reviewed annually. The service has a range of policies and procedures in place to support service delivery that have been reviewed regularly by the service. Staff are informed of any new/reviewed policies through handovers and meetings. There are regular management, service and clinical meetings and monthly quality risk and health and safety meetings. Quality data is presented at all meetings as described by staff and as documented in the quality and risk and health and safety meetings. The quality and health and safety meetings particularly, show extensive discussion of data with use to improve services. There is an opportunity to improve documentation of discussion in staff, registered nurse and caregiver meetings, noting that there is a broad approach to documentation of discussion evidence in the minutes. Caregivers confirmed that they are kept informed on quality data including corrective actions and quality initiatives. Trends are identified and analysed for areas of improvement. Noticeboards have meeting minutes, graphs and relevant data posted. The service is benchmarked against other facilities under the far Northland region. Statistics are collated and distributed three-monthly. The service is currently involved in the falls and pressure injury projects with the DHB. Internal audits are completed as scheduled, including environmental and clinical audits. Corrective action plans are raised, completed and signed off for any corrective actions required. The quality and risk coordinator provides a monthly quality report to the clinical manager and board. There are annual resident and relative satisfaction surveys. The surveys of 2018 and 2019

		show a very high level of satisfaction with this showing an improvement overall from the 2017 surveys completed. General satisfaction in 2018 and 2019 was at 100%. The quality risk coordinator is the health and safety coordinator and they have completed the health and safety course and transition course. There is an orientation and training programme in place around health and safety for board members, managers and staff. Health and safety information is displayed on the staff noticeboard. A staff wellness programme is implemented. Accidents, incidents and near miss forms are documented with data analysed. A hazard register is kept with evidence that hazards are eliminated or minimised at the earliest opportunity. There is also an up-to-date hazard register specifically related to resident care. A board and management member is on the H&S committee. Three workers are qualified health and safety representatives with a focus on more staff being trained in the role.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	As part of risk management and the health and safety framework, there is an accident/incident policy. The service collects incident and accident data monthly and provides reports to the management, health and safety committee, clinical and facility meetings. Accident and incident data, trends and corrective actions are discussed and actioned in quality and health and safety meeting minutes documented. The quality and risk coordinator takes responsibility for ensuring that the register is updated. Staff stated that these are also discussed at other meetings. Fifteen incident forms were reviewed from March 2019. All incident forms are on the online system. All incident forms reviewed identified a timely RN assessment of the resident, corrective actions or recommendations and all had been completed and signed off by the clinical manager. Neurological observations are taken and recorded appropriately for those who have had an unwitnessed fall or head injury. The next of kin have been notified for all incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The clinical manager has completed a one-off audit of completion of incident process and documentation of observations. The CEO and clinical manager could describe situations that would require reporting to relevant authorities. The service has reported three Section 31 notifications since the last audit. These issues were resolved in a timely manner.
Standard 1.2.7: Human Resource Management Human resource management processes	PA Low	There are human resources policies to support recruitment practices. The register of practising certificates for registered nurses and allied health professionals is current. Ten staff files were reviewed (chief executive, clinical manager, two registered nurses, two caregivers, one cook, one activities coordinator, assistant clinical manager and one operations support manager

are conducted in accordance with good employment practice and meet the requirements of legislation.		person). All files contained relevant employment documentation including police vetting, references and evidence of a completed orientation. The orientation programme provides new staff with relevant information for safe work practice. Care staff could describe the orientation process and believe new staff are adequately orientated to the service. The staff development training coordinator is a registered nurse and they maintain a record of all staff training. They are a Careerforce assessor and the role includes ensuring that staff are orientated and trained adequately for the role they are in. There is an education plan that covers all the mandatory education requirements. Registered nurses and caregivers have access to external training which includes clinical education relevant to medical conditions such as the palliative care course. Staff are expected to complete an annual performance appraisal. Staff are encouraged to complete Careerforce training. In-service days delivered on site by internal and external educators cover mandatory training. Several training days are offered throughout the year, ensuring all staff attend. Five registered nurses (including two-unit managers and the assistant and clinical managers) are interRAI competent. Staff complete competencies relevant to their roles. There are 25 caregivers who have completed required dementia standards. Of these, there are 15 caregivers who work in the dementia unit with others able to work when staff are on leave.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The clinical manager and assistant clinical manager are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns. There is at least one registered nurse on duty at all times. There are sufficient caregivers on duty and a “floater” available between the units. The hospital unit (Robinson with 30 residents) has the following caregivers on duty: morning shift - three caregivers on full shift and three caregivers on short shifts; afternoon shift - two full shifts and three short shifts and; two on night shift. The rest home (Paterson with 20 residents) has the following caregivers on duty: morning shift – two caregivers on full shift; afternoon shift - two full shift and one short shift and; one on night shift. The dementia unit (Tui with 15 residents) has the following caregivers on duty for: morning shift - one caregiver on full shift and one caregiver on short shifts; afternoon shift - one full shift and

		one short shift and; one on night shift. Residents and relatives stated there are adequate staff on duty at all times. Staff stated they feel supported by the clinical manager and assistant clinical manager who respond quickly to after-hours calls.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. All policies and procedures had been adhered to. There are no standing orders. There are no vaccines stored on site. The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent HCAs administer medications. All staff have up-to-date medication competencies and there has been medication education this year. The medication fridge

		temperature is checked daily. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Sixteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has a chef who works Monday to Friday 0700-1530. There are two other cooks on a rolling roster who work from 0830-1700. There are two kitchenhands on a rolling roster who work 0600-1300. All kitchen staff have current food safety certificates. The chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in the rest home dining rooms from a bain marie. Meals are transported to the hospital dining room in a scan box and to the dementia room dining room in a hot box. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. There are snacks available at all times. All residents and family members interviewed were satisfied with the meals. The food control plan was verified on 30 January 2019.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) nutrition, pain, cognitive assessments and continence.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provided detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse and mental health care team for older people. The care staff interviewed advised that they were gradually learning the new electronic system and found writing on the tablets helpful.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. Four out of eight care plans sampled had interventions documented to meet the needs of the resident (link 1.3.5.2). Care plans have been updated as residents' needs changed. Resident falls are documented electronically on accident forms and in progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are documented electronically, and wound monitoring occurs as planned. There is one chronic wound which has had input from the GP. There are currently no pressure injuries

		Electronic monitoring forms are in use as applicable such as weight, vital signs, wounds and behaviour.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There are two diversional therapists and two activities assistants who cover seven days (for six hours a day) between them. One activities assistant has almost completed the diversional therapy course. There is also a large volunteer base. On the days of audit rest home residents were observed participating in fit for fun, doing craft work, playing games and listening to an entertainer. There is a two-weekly programme in large print on paper and the weekly programme is on whiteboards. The programme in the dementia unit can vary from the printed programme due to residents' mood and fatigue. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and crafts. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There is a chaplain who works four hours (but does many more) a week, and visits residents when requested and there is a church service every Sunday. Catholic volunteers come in to give communion weekly if requested. There are van outings for each unit weekly. There are two cats in residence, one in the rest home and one in the dementia unit. A pet therapy team visits twice yearly, and family members bring in their dogs. There are regular entertainers visiting the facility. Special events such as birthdays, Easter, Anzac Day, and Queen's birthday are recognised and celebrated. There is community input from volunteers who come in to have one-on–one chats and to read to residents. There are also visiting pre-schools and kindergartens. At present the activities staff are organising for a Kapa Haka group to visit. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly. Activity plans are not yet electronic, and evidence six-monthly reviews. Resident meetings are held monthly. Rest home residents interviewed stated that they enjoyed the activities. Family members of dementia unit residents stated that they are delighted that there is always something for their

		loved ones as well.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Six care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs (two were new admissions). Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan. Multi-disciplinary meetings include the RN, physiotherapist, GP when possible and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the mental health services for older people and the hospice. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness which expires 31 August 2019. There is a head maintenance person who works 40 hours a week and there are two other maintenance people who also work 40 hours a week. All three share the weekends on a rostered basis. They also cover the village. Contractors are available when required. Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The rest home and hospital communal lounges, hallways and bedrooms are carpeted. The dementia unit has a mixture of carpet and vinyl. Corridors are wide, have safety rails and

		promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are two enclosed outdoor areas for the dementia unit. There is an aviary between the dementia unit and the rest home for both units to enjoy. All outdoor areas have seating and shade. There is safe access to all communal areas. Staff interviewed stated they have adequate equipment to safely deliver care for rest home hospital and dementia level of care residents.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	The rest home has six rooms with ensuites. The rest of the rooms all have a hand basin but share a shower and toilet between two rooms. The hospital has nine rooms with ensuites. The rest of the rooms share hand basins, showers and toilets between two rooms. The dementia unit rooms all have their own hand basin but share communal showers and toilets. There are sufficient communal toilets and showers. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs. There are signs on all shower/toilet doors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are two double rooms in the facility, but these are only ever used as single rooms unless there is a married couple. All other rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The lounges/dining areas are large. There are smaller areas where residents who prefer quieter activities or visitors may sit. Activities occur in the larger areas or in the social room.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and	FA	All laundry is done off site. Cleaning services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There are two sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms are kept closed when not in

hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		use. Personal protective equipment is available.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. The Emergency Response and Recovery Plan is regularly updated and has been reviewed and approved by the DHB Integrated Operations and Emergency Manager. The Fire Evacuation Scheme was approved on 12 April 2005. All staff receive emergency training on orientation. A civil defence storage room includes supplies (torches/batteries, gas bottles, resident information including identification bracelets) and pandemic supplies all of which are checked six-monthly. Three generators are on site. Batteries to use for emergency power are also charged. There is enough water (four 600 litre header tanks and bottled water) and food for at least three days. Barbeques and gas bottles are available for alternative cooking. The fire evacuation scheme was approved by the fire service. Six-monthly fire drills are completed. There is a first aider on duty at all times with rosters reviewed confirming that his occurs. Resident's rooms, communal bathrooms and living areas all have call bells which are linked to pagers worn by staff. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. Security camera surveillance is installed in communal areas. There are infra-red rays that can be used to alert staff when a resident gets out of bed in the dementia unit. Staff stated that these are seldom used but can be used to monitor activity if required.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical and includes panel heaters and heat pumps. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free.
Standard 3.1: Infection control management	FA	There is an infection control coordinator (a RN) who is responsible for infection control across the facility. The coordinator liaises with and reports to the clinical manager. The responsibility for infection control is described in the job description. The coordinator collates monthly

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.		infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the clinical manager. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IC coordinator is an experienced RN, who has only been in the role for four months but has had infection control education. She has access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, and housekeeping incorporates the principles of infection control. The policies have input from an external infection control specialist.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there is training planned for 2019. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the clinical manager and at staff, quality and risk and RN meetings. Meeting minutes are available to staff. Trends are identified and analysed, and preventative measures put in place. The facility benchmarks with the Far North District benchmarking group. Systems

programme.		in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service philosophy around restraint is that it is used as an intervention that requires a rationale and is a last resort when other interventions or calming/defusing strategies have not worked. The service has worked to reduce the number of residents using restraint. There were three residents with enablers and seven with restraints (all hospital). Two enabler files sampled, and interview with one resident using an enabler, provided evidence that enabler use is voluntary.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	A registered nurse (also the quality risk coordinator) is the restraint coordinator with a defined job description. Restraint discussion and quality data around restraint and enabler use is included in the quality/risk meetings and clinical meetings. Care staff receive education on safe restraint use at orientation and annually. There is ongoing education including challenging behaviours. Staff complete restraint competencies.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, the resident and their family undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family are evident. A restraint assessment form had been completed for three resident files reviewed requiring restraint (sighted). Assessments identify risks related to the use of restraint and the specific interventions or strategies to try (as appropriate) before implementing restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the three care plans reviewed. Individual restraint monitoring booklets evidence

		checks, and cares have been carried out according to the documented frequency described in the resident care plan and monitoring tool. There is an up-to-date restraint register.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluations occur six-monthly as part of the ongoing review for residents on the restraint register and as part of their care plan review. Families (where possible) and the GP and RNs are included as part of this review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint usage is monitored regularly. The review of restraint use is discussed at the quality risk meetings and relevant facility meetings. The facility is proactive in minimising restraint. Internal restraint audits are completed six-monthly and demonstrate compliance of the standard.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The policy states that staff are expected to complete a performance appraisal annually. Six of the 10 files reviewed showed that they had completed a performance appraisal within the last year.	Four of the ten staff files reviewed did not evidence completion of an annual performance appraisal.	Ensure that all staff have an annual performance appraisal completed. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service is awarded a rating of continuous improvement for the continued focus on improving service delivery. Data is analysed and discussed with	Kerikeri Retirement Village is responsive to changing the service to meet the needs of residents. Over the past three years, it has also taken a proactive approach to improving service delivery with projects implemented, reviewed and monitored. These include a wellness programme for staff; the introduction and implementation of electronic systems to reduce inefficiencies including Time Target – for time in attendance software, eCase (installed two weeks prior to audit) and OneChart for medication administration; a new ‘farewell’ quilt for deceased residents, made by the community; buffet breakfast introduced into the rest home dining room with a high level of satisfaction documented; a senior management team that includes the chief executive. The general practitioner stated that clinically the service is sound with the new clinical manager providing new leadership at a high standard. The resident satisfaction survey completed in February 2018 showed a 100% satisfaction with care provided overall. The relative survey completed in 2017 showed a 90% satisfaction with the service and in 2018 and 2019 there was a 100% satisfaction recorded. These ratings were confirmed by all residents and family interviewed. Each person interviewed was also able to confirm changes to the service and to comment on increasing quality of service. Clinically there have been projects to improve care and outcomes for residents. These include a reduction in skin tears down from seven in January 2018 to one in December 2018 and from 39 overall in 2017 to 29 overall in 2018. Training

		evidence that this is used to improve service delivery.	around manual handling and use of equipment was linked to the improvement.

End of the report.