

Kiri Te Kanawa Retirement Village Limited

Current Status: 23 October 2013

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

General overview

Ryman Kiri Te Kanawa is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital level care for up to 89 residents. Occupancy is 16 rest home residents, 31 hospital residents, four residents in secure dementia unit and six rest home residents in the serviced apartments.

The facility manager has been in the role for the last two years and is supported by a clinical manager (new to the role since April).

There is a comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care. Staff turnover remains low.

Family members interviewed stated that they are involved in planning their family members care plan. Residents and family members interviewed all spoke positively about the care and support provided by staff at the facility.

Five of the six previous shortfalls identified at the previous audit have all been addressed.

This audit has identified improvements required around incident reporting, hazard identification, and aspects of care planning.

Audit Summary as at 23 October 2013

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 23 October 2012

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

Organisational Management as at 23 October 2012

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 medium or high risk and/or unattained and of low risk.
---	--	--

Continuum of Service Delivery as at 23 October 2012

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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Safe and Appropriate Environment as at 23 October 2012

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

Restraint Minimisation and Safe Practice as at 23 October 2012

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Infection Prevention and Control as at 23 October 2012

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

HealthCERT Aged Residential Care Audit Report (version 3.9)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

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

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

Audit Report

Legal entity name:	Kiri Te Kanawa Retirement Village Limited		
Certificate name:	Kiri Te Kanawa Retirement Village		
Designated Auditing Agency:	Health & Disability Auditing NZ		
Types of audit:	Surveillance		
Premises audited:	Kiri Te Kanawa Retirement Village		
Services audited:	Hospital – geriatric and medical, rest home, dementia		
Dates of audit:	Start date: 23 October 2012	End date: 24 October 2013	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			

Audit Team

Lead Auditor	XXXXXXXX	Hours on site	11	Hours off site	5
Other Auditors	XXXXXXXX	Total hours on site	11	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	1

Sample Totals

Total audit hours on site	22	Total audit hours off site	10	Total audit hours	32
Number of residents interviewed	7	Number of staff interviewed	13	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	67	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXXXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA Auditing Agency has finished editing the document.	Yes

Dated Friday, 15 November 2013

Executive Summary of Audit

General Overview

Ryman Kiri Te Kanawa is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital level care for up to 89 residents. Occupancy is 16 rest home residents, 31 hospital residents, four residents in secure dementia unit and six rest home residents in the serviced apartments.

The facility manager has been in the role for the last two years and is supported by a clinical manager (new to the role since April). A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Staff turnover remains low.

Family members interviewed stated that they are involved in planning their family members care plan. Residents and family members interviewed all spoke positively about the care and support provided by staff at the facility.

The six previous shortfalls identified at the previous audit have all been addressed.

This audit has identified improvements required around incident reporting, hazard identification, and aspects of care planning.

Outcome 1.1: Consumer Rights

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. An interpreter's policy is in place. The service has addressed their previous shortfall around keeping relatives informed. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. There is a complaints register that is up to date and includes relevant information regarding the complaint. Documentation including follow up letters and resolution demonstrates that complaints are well managed.

Outcome 1.2: Organisational Management

The service continues to implement the Ryman quality programme. A quality assistant checklist and RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six month period. There is an improvement required around incident reporting and hazard reporting. The service has addressed the previous shortfall around reporting pressure areas as incidents. Resident meetings are held on a two monthly basis in each area. Relative meetings are held six monthly. Annual resident and relative surveys are completed. The service continues to collect data to support the implementation of corrective action plans. The internal auditing annual schedule is implemented as per schedule.

Kiri Te Kanawa has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. The orientation/induction training for caregivers, on completion, is equivalent to foundations level two. There is a specific employees' induction manual. The 2013 in-service training programme identifies regular in-services. All staff working in the unit have completed or are in the process of completing the required dementia standards.

Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This

defines staffing ratios to residents. Rosters implement the staffing rationale.

Outcome 1.3: Continuum of Service Delivery

The registered nurse is responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required to ensure interventions in regards to pain assessments and weight loss is included in the care plan to reflect current needs. The previous shortfall around wound assessments and short term wound care plans has been addressed. Daily progress notes document all aspects of the residents care over a 24 hour period. This is an improvement from the previous audit. Short term care plans are utilised. Resident files are integrated and include notes by the GP and allied health professionals. The GP reviews the resident at least three monthly.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the resident group. Spiritual and cultural preferences and needs are being met.

Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities. There is weekly stock check of controlled drugs. This is an improvement since the previous audit.

Food services and all meals are provided on site and transported to hospital wing in hot boxes and the dementia unit in trolleys. Resident's individual food preferences and likes and dislikes are known to the food service. Nutritional profiles are completed on admission and forwarded to the kitchen. The cook is notified of any changes to resident's dietary needs. This is an improvement from the previous audit. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

Outcome 1.4: Safe and Appropriate Environment

The building has a current certificate for public use that expires September 2014. There is currently a 30 bed dementia care unit under construction. There is a fire evacuation letter of approval. A reactive and preventative planned maintenance schedule is in place. Clinical equipment is calibrated and checked annually.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint management policies and procedures are comprehensive; include definitions, processes and use of enablers. There are five enablers (bedrails) in use and four restraints (one lap belt and three bedrails). One enabler file was reviewed and included consents and assessments. One restraint file reviewed as a result of a restraint incident requires identified improvements.

Outcome 3: Infection Prevention and Control

All infections are collected via the 'infection report form' and all collected and discussed at the quality meetings. Following this the report information is entered onto the computer (Vcare) system and a collated report is generated. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents.

All meetings held include discussion on infection control. Internal audits are completed. Infections are benchmarked across the organisation.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	1	2	0	0
Criteria	0	38	0	1	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	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.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.3.9	Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;	PA Moderate	The following risk/hazard areas have not been identified on the hazard register: (i) There are two glass sliding doors from the external outside area into the dementia unit. The first door is on a sensor and automatically opens from the outside. The second door then requires a keypad pin to open. Advised that relatives/visitors ring	Ensure all hazards are addressed and actions are identified/implemented and monitored to manage the risk	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		(b) A process that addresses/treats the risks associated with service provision is developed and implemented.		<p>from the phone within the cavity area of the two doors to be let into the unit. There are currently no portable phones in the dementia unit and one staff member on each shift. Advised by one relative and a staff member that at times there have been nobody near the phone to answer at which time the visitor is trapped between the two doors as a keypad pin is then required to exit, (ii) on the day of audit it was observed that a resident was escorted by a relative and staff member outside the unit and the first glass door did not automatically close after they exited. The staff member had to climb up and manually close the doors. Advised this has occurred on other occasions and the maintenance person has been called to fix it. This was addressed on the day. (ii) Meeting minutes and H&S report identifies incidents of burns from bain maries. While this was discussed at the H&S meeting and the bain marie turned off permanently in the dementia unit, the hazard</p>		

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				is not included in the hazard register		
HDS(C)S.2008	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.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	(i)One hospital resident with chair briefs had four documented incidents of falls out of a chair while restraint in place. Care plan was not updated to identify the increased risk including the need for increase monitoring. (ii) One rest home resident had two documented incidents of wondering. Progress notes reviewed also identified incidents of the resident getting in to other resident's beds. Risks and increased monitoring not identified in care plan. (iii) Monthly incident analysis form reviewed June and August did not align with the Vcare summary (benchmarking). (iv) analysis of incidents was not clearly documented to identify opportunities for improvement: eg: no corrective actions were established at a facility level for five pressure areas identified in August	(i)-(ii) ensure where corrective actions are required for individual incidents that these area documented and implemented, (iii) ensure the monthly analysis form aligns with benchmarking stats provided to head office, (iv) ensure analysis of incidents includes documented/implemented corrective actions at a facility level to minimise further incidents, (v) complete corrective actions in a timely manner for identified trends.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>or four pressure areas in Sept. (v) A six month comparative summary is completed to identify trends and actions required. The Oct 12 – Mar 13 (which identified increase in skin tears hosp/rest home and increased falls hosp) comparative summary included a belated documented corrective action plan 6/6/13..</p>		
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	<p>i)There is no pain assessment for wound pain as identified in the on-going wound evaluation for one rest home resident. This is a new finding raised in regards to wound management. ii)Written evaluations regarding weight loss interventions and management has not been updated on the long term care plan for one hospital resident. iii)There is no pain assessment for a respite resident on return to the facility following surgery. Interventions on the long term care plan for one hospital resident</p>	(i)and (iii) Ensure pain assessments/management are in place for chronic, new or exacerbations of pain including wound pain; ii) Ensure changes to health identified in written evaluations are updated in the long term care plan.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				regarding pain relief does not reflect current pain status.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

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

Consumers receive services in accordance with consumer rights legislation.

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Consumers are informed of their rights.

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:

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

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: Not Audited
Evidence:

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

ARHSS D16.5e

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise. Access to interpreter services is identified in the community. This includes language support, the DHB, Hearing Association and the Blind Foundation. ARC D11.3 The information pack is available in large print and advised that this can be read to residents. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The

Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry
D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Interviews with six relatives (three hospital, two rest home and one dementia) all confirmed that they are always informed when their family members health status changes.

A sample of incidents forms reviewed from October (three dementia, four rest home, 13 hospital, one serviced apartment) identified that all 21 incident forms evidenced that family were contacted. The previous audit identified that there was a shortfall around informing family following an incident. This audit identified that this has been addressed.

Two monthly resident meetings and six monthly relative meetings in each area includes feedback.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:

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

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

Consumers have access to visitors of their choice.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: Not Audited

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

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

Attainment and Risk: FA
Evidence: <p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on VCare. Complaints and verbal complaints reviewed for 2013 (In the hospital, one written, one verbal: In the rest home, one verbal, four written) all were tracked, indicating that they had been actioned according to timeframes and identified resolution. The monthly staff meeting identified discussion of complaints and opportunities for improvement in service delivery.</p> <p>Interviews with six relatives and seven residents confirmed that they were well informed around the complaint process.</p> <p>D13.3h. a complaints procedure is provided to residents within the information pack at entry. E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on: 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Ryman Kiri Te Kanawa is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital level care for up to 89 residents, including 20 certified serviced apartments. Occupancy is 31 rest home residents and 16 hospital residents. There are four residents in secure dementia unit and six rest home residents in the serviced apartments. Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. To monitor organisation performance, the manager reports weekly to head office and RAP committee meetings occur monthly. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme (RAP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation and there are clear guidelines and templates for reporting. The service has in place an experienced and village manager who is supported by an experienced clinical manager.

ARC E2.1, The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life

and minimises risks associated with their confused states.

ARC, D17.3di (rest home), D17.4b (hospital), the facility manager and clinical manager has maintained at least eight hours annually of professional development activities related to management. The facility manager has been in the role for the last two years and has previous aged care management experience within Ryman. She is supported by an experienced clinical manager (who has been in role since May) and Ryman regional manager.

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

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

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

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

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

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

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

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: PA Moderate
Evidence: Kiri Te Kanawa has an established quality and risk management system that is directed by head office. The RAP includes a schedule across the year for the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Kiri Te Kanawa at the onsite monthly RAP meetings and weekly management meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with a registered nurse and six caregivers and review of meeting minutes demonstrate their involvement in quality and risk activities. The monthly staff meeting (full facility RAP meeting) included

discussing progress of 2013 quality goals.

Resident meetings are held on a two monthly basis in each area. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed. 2013 resident survey recently completed and they are awaiting the results. A review of 2012 survey identified three issues around meal presentation, laundry and delay in maintenance. Quality actions were established and implemented around those issues and a review of resident meetings identify an increased satisfaction.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. The RAP programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar (sited).

There are adequate clinical policies and procedures to rest home, hospital and dementia level care. The two monthly journal club (attended by registered/enrolled nurses), directed by head office, reviews the latest clinical practice articles.

A quality assistant checklist and RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. a) There are monthly accident/incident reports completed that break down the data collected across each area in the facility (link improvements 1.2.4.3). Reports are provided from the manager to head office that includes a collation of staff incidents/accidents and resident incidents/accidents. Kiri Te Kanawa also provides a six monthly comparative summary report that includes recommendations for residents and staff and training conducted(link improvements 1.2.4.3).. These are also compared with the previous month. b) The monthly manager's report includes complaints/concerns/compliments. All complaints are attended to through the monthly RAP meeting. Quality improvement plans are initiated where required. c) All infections are documented in a monthly summary report and discussed in the monthly RAP committee meetings and two monthly health and safety/IC meetings. Monthly reports to head office include a monthly summary of infections, statistics, clinical summaries and education. d) Health and safety is addressed through the two monthly health and safety meetings (link improvements 1.2.3.9)., e) The restraint approval group meets six monthly. Monthly benchmarking occurs throughout the group.

The service collects data to support the implementation of corrective action plans(link improvements 1.2.4.3). The internal auditing annual schedule is implemented as per schedule. Meetings are minuted including actions to resolve areas identified for improvement and quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement.

D19.3 Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. A health and safety officer is appointed. Risk management, hazard control and emergency policies and procedures are in place. However, the hazards register does not include all identified hazards and this is identified as an opportunity for improvement. The organisation's benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls and the implementation of the Triple A exercise programme. Sensor mats are in place and manual handling training is provided to staff. In June 2013 there was 22 falls identified in the hospital and 16 falls identified in July 2013, the service put in place corrective actions including falls prevention training conducted every shift until 100% staff had attended. Falls were minimised in August 2013.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: PA Moderate
Evidence: Health and Safety Policies are monitored by the health and safety committee two monthly meetings. These are combined with infection matters. There is a dedicated health and safety officer, including a job description for the position. There is a hazard register that records environmental issues and outcomes.
Finding: The following risk/hazard areas have not been identified on the hazard register: (i) There are two glass sliding doors from the external outside area into the dementia unit. The first door is on a sensor and automatically opens from the outside. The second door then requires a keypad pin to open. Advised that relatives/visitors ring from the phone within the cavity area of the two doors to be let into the unit. There are currently no portable phones in the dementia unit and one staff member on each shift. Advised by one relative and a staff member that at times there have been nobody near the phone to answer at which time the visitor is trapped between the two doors as a keypad pin is then required to exit, (ii) on the day of audit it was observed that a resident was escorted by a relative and staff member outside the unit and the first glass door did not automatically close after they exited. The staff member had to climb up and manually close the doors. Advised this has occurred on other occasions and the maintenance person has been called to fix it. This was addressed on the day. (ii) Meeting minutes and H&S report identifies incidents of burns from bain maries. While

this was discussed at the H&S meeting and the bain marie turned off permanently in the dementia unit, the hazard is not included in the hazard register

Corrective Action:

Ensure all hazards are addressed and actions are identified/implemented and monitored to manage the risk

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

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

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

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

Attainment and Risk: PA Moderate

Evidence:

The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH.

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. A six monthly comparative analysis is completed of incidents for internal benchmarking across Ryman's facilities. In addition, each facility receives an analysis of the last three six monthly periods from which to identify trends and improvements. However, improvements are required around timeliness and alignment of benchmarking data. Minutes of the monthly RAP committee meetings, two monthly health and safety meetings and monthly full facility meetings reflect a discussion of incidents/accidents. Falls rates are compared to indicators from the "Standard on safe indicators in aged care".

Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. A sample of incidents forms reviewed from October (three dementia, four rest home, 13 hospital, one serviced apartment) identified that all 21 incident forms were fully completed and included registered nurse assessment, however two identified lack of implemented follow up.

D19.3b; there is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

A sample of incidents forms reviewed from October (three dementia, four rest home, 13 hospital, one serviced apartment) identified that all 21 incident forms were fully completed and included registered nurse assessment, however two identified lack of implemented follow up.

Finding:

(i)One hospital resident with chair briefs had four documented incidents of falls out of a chair while restraint in place. Care plan was not updated to identify the increased risk including the need for increase monitoring. (ii) One rest home resident had two documented incidents of wondering. Progress notes reviewed also identified incidents of the resident getting in to other resident's beds. Risks and increased monitoring not identified in care plan. (iii) Monthly incident analysis form reviewed June and August did not align with the Vcare summary (benchmarking). (iv) analysis of incidents was not clearly documented to identify opportunities for improvement: eg: no corrective actions were established at a facility level for five pressure areas identified in August or four pressure areas in Sept. (v) A six month comparative summary is completed to identify trends and actions required. The Oct 12 – Mar 13 (which identified increase in skin tears hospital/rest home and increased falls hospital) comparative summary included a belated documented corrective action plan 6/6/13.

Corrective Action:

(i)-(ii) ensure where corrective actions are required for individual incidents that these area documented and implemented, (iii) ensure the monthly analysis form aligns with benchmarking stats provided to head office, (iv) ensure analysis of incidents includes documented/implemented corrective actions at a facility level to minimise further incidents, (v) complete corrective actions in a timely manner for identified trends.

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

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

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

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

Attainment and Risk: FA

Evidence:

A register of registered nurse practising certificates is maintained within the facility. The current general practitioners' registration is printed from the professional body's website. Allied health practitioners are asked to provide evidence of registration as appropriate (for example, physiotherapist and

podiatrist) and a copy is retained by the facility.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed. All had completed reference checks, orientation and up to date appraisals.

Kiri Te Kanawa has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as (but not limited to) caregiver, senior caregiver, registered nurse, H&S rep, clinical manager and gardener.

The orientation/induction training for caregivers, on completion, is equivalent to foundations level two. There is a specific employees' induction manual.

Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent. The orientation process includes; full induction with all employees and caregiver modules followed by enrolment into the ACE programme to achieve ACE core, ACE advanced and/or ACE dementia, as appropriate, if not achieved prior to employment.

The 2013 YTD in-service training programme identifies 29 training sessions completed between April – Oct 13. A review of staff training records identified average attendance and staff also complete staff comprehension surveys at least two annually.

Registered nurses are supported to maintain their professional competency and there is also a foreign trained nurse development programme. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. The journal club has completed training (YTD) around UTI's, advance care planning, informed consent, code of rights and palliative care. Yearly formal performance review specific to RNs for reflective practice and setting goals including up skilling or other training or qualification goals.

E4.5d: the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5f: There are eight caregivers in the dementia unit, seven have completed the required dementia standards, and one caregiver is in the process of completing.

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.
There is a clinical manager Tues – Sat and another RN rostered on the morning shift, afternoon and night shift.
In the serviced apartments there is a coordinator every morning 0800 – 1630, another caregiver 0700 -1300 and a caregiver 1630 – 2100.
In the dementia unit (four residents) there is one caregiver rostered each shift with support by the rest home/hospital as required. Caregivers in the dementia unit also provide activities to their residents with support by the activity team.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: <p>The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs. Of admission. The nursing care assessments and long term care plans align with the service delivery policy.</p> <p>Clinical staff have attended in-service and refreshers on clinical care including person centred care, skin integrity, personal hygiene, Liverpool care pathway, first aid and challenging behaviour.</p> <p>Activity assessments and activities care plans have been completed by the activity co-ordinators.</p> <p>A physiotherapist is contracted to the service to undertake new resident physio assessments and follow up any referrals. The podiatrist visits regularly.</p> <p>A dietitian has been recently contracted to the service.</p> <p>D16.2, 3, 4; An initial assessment and initial care plan is completed within the required timeframes. The long term care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. Three rest home (including one residents in the serviced apartments, one respite care), two hospital and one dementia resident files were reviewed. All five long term files identified the initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe. One respite resident had a short term care plan in place.</p> <p>D16.5e; Medical assessments were documented in all five long term files within 48 hours of admission. Three monthly medical reviews were documented in five of five files by general practitioner. It was noted in the resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. More frequent medical assessment/ review noted occurring in residents with acute conditions and those with complex medical conditions.</p> <p>Medical care is provided by GP's from several local practices. The GP interviewed visits weekly and conducts three monthly reviews and visits residents of concern. The GP is notified promptly by fax or phone with any resident concerns and states the RN's have good clinical assessment skills. Each GP surgery has a GP communication book.</p> <p>There is a good liaison and communication with the DHB needs assessment team, geriatrician and mental health team for the older persons.</p> <p>Assessment tools completed on admission include a) waterlow pressure area risk assessment, b) skin integrity, c) continence, d) coombes falls risk, e) dietary profile f)</p>

pain/Abbey scale assessment g) physiotherapy assessment. h) behavioural assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

Six caregivers (two rest home, two hospital, one serviced apartments and one dementia care) interviewed could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a communication book and Duty Handover form which is completed for each shift that lists any residents requiring any special observations or needs. Progress notes are written on every shift.

The previous audit identified that progress notes were not regularly completed or followed through. This audit identified that they are written on at least daily and more frequently for any significant events. This is an improvement from the previous audit.

Six resident files sampled included three rest home, two hospital and one special care unit resident.

Tracer methodology: rest home resident

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

Tracer methodology: dementia care resident

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

Tracer methodology: Hospital resident

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: Not Audited
Evidence:

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: PA Low
Evidence: <p>Six resident files were reviewed (three rest home (including one rest home residents in serviced apartments), two hospital and one dementia unit). Residents interviewed (three hospital , two rest home) report their needs are being appropriately met. Relatives interviewed (three hospital, one dementia care, two rest home and two serviced apartments) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. Care plan includes; cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, medication, ADLs, skin, wound and pressure care, pain, dietary/diabetes management, and social, spiritual, cultural and sexuality. Interview with six registered nurses verified involvement of families in the care planning process. Relatives interviewed confirm they are informed of any changes to their relative’s health and interventions required to meet the resident’s needs. There is evidence in the progress notes (with a relative contact stamp) that next of kin have been contacted and a record of the discussion held.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and wound management plans/skin tear plans are in place for one skin tear, two leg ulcers and one pressure area sacrum (hospital level), hand lesion (rest home) and a chronic leg wound in the serviced apartments. There are currently no wounds or skin tears in the dementia unit. Each unit has a wound folder has a wound and skin tear register. Wound mapping charts are evident as required. The service has access to district nurses or wound specialist by referral as required. The RN's interviewed (two) described access to external to wound specialist as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the two RN's interviewed.</p> <p>Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an assessment form for at risk residents. Accident and incidents are investigated for cause and corrective actions include the use of hip protectors, clutter free rooms and mobility aids available. A falls response protocol is completed for frequent fallers.</p>

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

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

Attainment and Risk: PA Low

Evidence:

Evaluations, wound assessments and pain level is carried out at each dressing change. The chronic wound for one rest home resident is linked to the long term care plan. A previous shortfall around the documenting the type of wound and short term care plans for wounds has been addressed.

ii) Weigh chair scales are used to weigh residents monthly. Weight loss short term care plans include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/Dietitian notification.

iii) Verbalising and non-verbalising pain assessments (Abbey pain scale) are available for use on resident admission as applicable and reviewed at least six monthly. Pain assessments for on-going pain and evaluation forms are in place.

Finding:

i) There is no pain assessment for wound pain as identified in the on-going wound evaluation for one rest home resident. This is a new finding raised in regards to wound management.

ii) Written evaluations regarding weight loss interventions and management has not been updated on the long term care plan for one hospital resident.

iii) There is no pain assessment for a respite resident on return to the facility following surgery. Interventions on the long term care plan for one hospital resident regarding pain relief does not reflect current pain status.

Corrective Action:

(i) and (iii) Ensure pain assessments/management are in place for chronic, new or exacerbations of pain including wound pain; ii) Ensure changes to health identified in written evaluations are updated in the long term care plan.

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

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

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

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

Attainment and Risk: FA

Evidence:

There are three activity coordinators that provide separate activity programmes for the rest home, hospital, dementia care unit and serviced apartments. The activity co-ordinator for the rest home/hospital/dementia care unit is a qualified registered diversional therapist (DT). A replacement activity co-ordinator for the rest home is being orientated. There is a casual activity co-ordinator that provides cover for each of the unit co-ordinators as required. The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are displayed on notice boards around the facility. There is a core programme which includes the triple A (Active, Ageless, Awareness) exercise programme that was designed by the Ryman group and includes exercises for less active residents and a more active exercise programme for mobile residents and serviced apartments. Triple A programme in the dementia unit also includes meaningful activities for the resident such as folding washing, dusting and knitting. This is a comprehensive programme that meets the needs of all consumers. The resident is assessed and with family involvement if applicable, interests and hobbies etc. are discussed. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment and 'your life experiences'.

There is an aim to review the activity and clinical care plan at the same time with resident/family, RN and activity co-ordinators involved in the review. The activity care plan is reviewed at least six monthly. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. A resident attendance list for activities, entertainment and outings is maintained. There are activities and entertainment scheduled that is open to all residents to attend as desired. There are regular outings and van rides for each unit. Group activities offered include crafts, movies, baking, walks, card making, card games, newspaper reading, movies and bingo. Visitors to the site include inter-home visits, pet therapy, school visits and church groups. Resident participation is voluntary. One on one activities are provided for residents as assessed.

Resident meetings are held and feedback to activities is provided at the meeting. The activities co-ordinators attend all relevant on-site education and DT meetings in the community.

All five (two rest home and three hospital) residents and eight (two rest home, three hospital, one dementia care and two serviced apartments) family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d Six resident files reviewed (three rest home, two hospital and one dementia) identified that the individual activity plan is reviewed at least six monthly with an aim to review at care plan review.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited in resident files). Short term care plans are utilised in the rest home, hospital, and dementia unit. Short term care plans sighted are for chest infection, skin tear, UTI, weight gain, weight loss. Short term care plans are evaluated at regular intervals and problems are either resolved or transferred to the long term care plan as an on-going problem. Any changes to the long term care plan are dated and signed (link 1.3.6.1). The GP reviews the resident at least three monthly

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

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

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

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

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

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: <p>The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Any discrepancies are fed back to the pharmacy. The medication trolleys are kept in a locked treatment room in the rest home/hospital and dementia care unit. RN's in the hospital and senior caregivers in the rest home and dementia care unit are competency assessed six monthly. Medication education is attended annually. RN's complete syringe driver training and are supported by the local hospice nurses and specialist. Controlled drugs are stored in the hospital controlled drugs safe. There are medications standing orders in place for each GP. Verbal orders are used as required. There are no self-medicating residents. Administration signing sheets are correct and complete. Prn medications administered have a time of administration recorded. Controlled drugs are signed as given by two medication competent staff. Controlled drugs stock is checked weekly. This is an improvement from the previous audit. There is also a pharmacy audit six monthly. Medication fridge temperatures are monitored weekly. The dementia care medication fridge is not currently in use. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. 12 of 12 medication charts sampled have photos and allergies/adverse reaction documented. D16.5.e.i.2; 12 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets. There is a qualified chef Monday to Friday and a weekend/reliever cook. The cooks are supported by a morning and afternoon kitchen hand. The four weekly summer and winter menu is designed and reviewed by a Registered Dietitian at an organisational level. The menu can be changed in consultation with the dietitian to accommodate resident choice. The chef receives a resident diet requirement for each new admission and any changes to resident's dietary needs are communicated to the kitchen. Special diets (gluten free, diabetic puddings, vegetarian, and moulid) and resident likes/dislikes are known by kitchen staff. Alternative choices are offered.</p> <p>All meals are cooked in the main kitchen and are transferred to the rest home, hospital and serviced apartments in insulated containers. Trays of food are then removed from the insulated transfer boxes and placed in warmed bain maries. Caregivers serve meals in the hospital and rest home. The meals are served on individual trays for the dementia unit residents and transported in trolleys with heat lids. Special diets are name labelled. The chef is notified if the dietitian has been involved in any residents with dietary concerns such as weight loss/gain or swallowing difficulties. Nutritious snacks are available over 24 hours for residents in all units. Food on the</p>

Run platters are seen in the dementia unit and there are individual morning and afternoon tea platters for the resident with a variety of finger foods. The service has a large workable kitchen that contains a walk-in chiller, freezers, walk-in pantry, gas hobs and oven, two combi ovens and a deep fryer. The kitchen work flow has defined areas for dishwashing, baking, cooking, delivery and storage areas. The freezer and chiller temperatures are recorded daily. All fridges in the kitchenettes are monitored daily. Perishable foods are date labelled. Internal monitoring of food temperatures occurs over two days every three months. Twice daily hot food monitoring has commenced to align with current best practice as per the food services policy. The kitchen equipment is on a planned maintenance schedule six monthly. Ecolab provide the chemicals, safety data sheets and chemical safety training as required. Quality control checks are carried out on the dishwasher. The kitchen is locked after hours and the chemicals are stored safely in chemical storage room. Ecolab conduct pest control management. Fly screens are place. A fire extinguisher and fire blanket is readily accessible. A first aid kit is available in the kitchen. Feedback on the service is received form the resident and family meeting (cooks attends), satisfaction surveys and internal monitoring. D19.2 staff have been trained in safe food handling. All residents have a dietary profile completed on admission. The kitchen is notified of admissions and any dietary changes as required. The shortfall in the previous audit around nutritional profiles is now fully attained

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA
Evidence: There is a certificate for Public Use that expires September 2014. There is currently construction of a 30 bed dementia unit on the second floor. The fires service

evacuation approval is dated 16 April 2012. All electrical equipment has been checked September 13 and clinical equipment has been calibrated September 2014. Link improvements 1.2.3.9.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: Not Audited
Evidence:

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The restraint management policies and procedures are comprehensive; include definitions, processes and use of enablers.

The Restraint Minimisation Manual identifies that enablers are voluntary and the least restrictive option. There are five enablers (bedrails) in use and four restraints (one lap belt and three bedrails). One enabler file was reviewed and included consents and assessments. One restraint file reviewed as a result of a restraint incident requires identified improvements (link 1.2.4.3)

E4.4a: the care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

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.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;

- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:

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

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited

Evidence:

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: Not Audited
Evidence:

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: Not Audited
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

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

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: Not Audited
Evidence:

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: Not Audited
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: FA
Evidence: All infections are collected via the 'infection report form' and all collected and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report of generated. Trends and individual outcomes are noted and acted upon by the service.

Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers. The IC Officer (clinical Manager) then reports infection stats to the bimonthly H&S/IC meetings and a six monthly comparative summary is completed and forwarded to head office. All meetings held include discussion on infection control. Internal audits are completed. Infections are benchmarked across the organisation. A rotavirus outbreak between 9- 20 August 2013 (involved two serviced apartment residents, eight rest home and seven hospital) was managed efficiently with reporting and records well maintained. An outbreak management meeting was also held.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

