

Hilda Ross Retirement Village Limited

Current Status: 19 November 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 Hilda Ross is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital level care for up to 158 residents. Occupancy is 67 rest home residents, 43 hospital residents, 40 residents across the two secure dementia units and eight rest home residents in the serviced apartments. The facility manager has been in the role since March 2013 (was previous assistant manager at Hilda Ross) and is supported by a clinical manager (new to the role).

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. There have been no serious complaints since the previous audit. Residents and family members interviewed overall all spoke positively about the care and support provided by staff at the facility.

Three of five shortfalls identified at the previous audit have been addressed related to family input into care plans, progress notes and controlled drugs. Improvements continue to be required around medication documentation and care planning interventions. This audit has identified further improvements required around incident reporting, infection surveillance, restraint evaluations and aspects of care planning.

Audit Summary as at 19 November 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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	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 19 November 2013

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 19 November 2013

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

Continuum of Service Delivery as at 19 November 2013

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

Safe and Appropriate Environment as at 19 November 2013

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 19 November 2013

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

Infection Prevention and Control as at 19 November 2013

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

HealthCERT Aged Residential Care Audit Report (version 3.91)

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:	Hilda Ross Retirement Village Limited
Certificate name:	Hilda Ross Retirement village
Designated Auditing Agency:	HDANZ
Types of audit:	Surveillance
Premises audited:	Hilda Ross Retirement village, 30 Ruakura Road, Hamilton
Services audited:	Rest Home, Hospital – geriatric and medical, dementia
Dates of audit:	Start date: 19 November 2013 End date: 20 November 2013
Proposed changes to current services (if any):	
	The 28 bed rest home extension wing was reviewed to be suitable to provide rest home or hospital level care
Total beds occupied across all premises included in the audit on the first day of the audit:	158

Audit Team

Lead Auditor	XXXXX	Hours on site	14	Hours off site	6
Other Auditors	XXXXX	Total hours on site	14	Total hours off site	5
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	28	Total audit hours off site	12	Total audit hours	40
Number of residents interviewed	11	Number of staff interviewed	23	Number of managers interviewed	6
Number of residents' records reviewed	9	Number of staff records reviewed	8	Total number of managers (headcount)	3
Number of medication records reviewed	18	Total number of staff (headcount)	155	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXX, 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 has finished editing the document.	Yes

Dated Monday, 13 January 2014

Executive Summary of Audit

General Overview

Ryman Hilda Ross is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital level care for up to 158 residents. Occupancy is 67 rest home residents, 43 hospital residents, 40 residents across the two secure dementia units and eight rest home residents in the serviced apartments.

The facility manager has been in the role since March 2013 (was previous assistant manager at Hilda Ross) and is supported by a clinical manager (new to the role).

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. There have been no serious complaints since previous audit.

Residents and family members interviewed overall all spoke positively about the care and support provided by staff at the facility.

Three of five shortfalls identified at the previous audit have been addressed related to family input into care plans, progress notes and controlled drugs.

Improvements continue to be required around medication documentation and care planning interventions.

This audit has identified further improvements required around incident reporting, infection surveillance, restraint evaluations 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 Ryman Accreditation Programme (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 analysing incident stats. 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 internal auditing annual schedule is implemented as per schedule.

Hilda Ross 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 dementia units 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

Service delivery plans demonstrate service integration. Assessments and support plans identify who is responsible for the actions. Nursing care plans reviewed were individualised and up to date. Care plans are goal oriented and reviewed at least six monthly. There are improvements required around care planning, restraint management for one resident, wound management and weight loss management.

There is a comprehensive activities programme at Hilda Ross. Activities are varied, age appropriate and include inclusion at local community and entertainment events. Independent programmes run in the rest home, the serviced apartments, dementia unit and the hospital.

The medication management system is appropriate. Improvements have been completed since previous audit around controlled drugs. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents' general practitioner at least three monthly. Individual resident's medication charts were sighted. There are improvements required around medication administration and dating of open eye drops.

The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission This is reviewed six monthly as part of the care plan review. Relative and resident meetings are held and meals are discussed. All residents interviewed stated that the food was excellent.

Outcome 1.4: Safe and Appropriate Environment

Legislation and regulatory requirements continue to be met for local authorities and the MoH. Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness, which expires on 8 May 2014. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2013. The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. Handrails are available around the hallways. There is adequate space around the facility for storage of mobility equipment.

There is an outside area with shade and seating that is observed to be well maintained with paths and handrails.

The rest home extension wing was verified as suitable to provide rest home or hospital care. The rooms and ensuites are large enough to manage mobility equipment. There is communal mobility toilets. The lounge and dining area is adequately size for increase in lazy boys or mobility equipment

Outcome 2: Restraint Minimisation and Safe Practice

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 three enablers (bedrails) in use and three restraints (bedrails). One enabler file was reviewed and included consents and assessments. There is an improvement required around restraint evaluations.

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 includes discussion on infection control. Internal audits are completed. Infections are benchmarked across the organisation. There is an

improvement required around follow through of meeting minutes.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	12	0	3	3	0	0
Criteria	0	38	0	3	3	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	32
Criteria	0	0	0	0	0	0	0	57

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Low			
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 Low	A review of incident stats across 2013 identified that pressure areas were high for April (7) May (6) and June (6) in the hospital. No corrective actions were established. Incident and accident analysis has been completed monthly but lacks detail/trends and	Ensure analysis of incidents includes documented/implemented corrective actions at a facility level to minimise further incidents	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				corrective actions. However, improvements to incident and accident analysis were noted from August 2013.		
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	(i)Six of nine care plans sampled do not have interventions relating to all areas of need. Examples include MRSA, falls risk management, pressure area risk management and weight loss. (ii) One resident in the dementia unit who has a possible delirium and one resident in the hospital with reddened areas in the groin requiring creams do not have short term care plans relating to these needs.	Ensure that all areas of identified need have related interventions in care plans. (ii) Ensure that short term care plans are used to address short term needs.	30
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 Moderate			
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 Moderate	(i)One resident in the hospital has her only functioning hand bandaged to prevent her removing her naso gastric tube. There has been no restraint	(i) Ensure that all residents using restraint have a documented assessment and plan around this. (ii) Ensure weight loss is appropriately managed including care plan	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>assessment completed or plan developed. (ii) Two residents in the dementia unit have had weight loss of in excess of 10 kg between February 2013 and September 2013. Neither has been referred to a dietitian and one does not have weight loss addressed in the care plan. The other does not have current interventions (fortisip) addressed in the care plan. One of these residents is prescribed TDS complan but food and fluid recording charts show she is not receiving this TDS. (iii) Nine of 42 wounds have not always been reviewed in the stated timeframes. In most cases this is for minor wounds with a delay of one to two days on one to two occasions. One skin tear scheduled to be reviewed every third day had a delay between reviews of seven days.</p>	<p>documentation, dietitian referrals and residents receiving prescribed supplements. (iii) Ensure that all wounds are reviewed within stated timeframes.</p>	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Moderate	(i)Five of 18 medication charts sampled have at least one dose of regular medication that has not been signed as administered. (ii) There is one bottle of open eye drops in the serviced apartment area and two bottles in the rest home extension that have not been dated when they were opened.	(i)Ensure all medications are documented as administered as prescribed. (ii) Ensure all eye drops are dated when they are opened.	30
HDS(RMSP)S.2008	Standard 2.2.4: Evaluation	Services evaluate all episodes of restraint.	PA Low			
HDS(RMSP)S.2008	Criterion 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;	PA Low	In the two restraint files reviewed evaluations had not been completed on a regular basis	Ensure evaluations are completed as per timeframes identified via the assessment process	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>				
HDS(IPC)S.2008	Standard 3.5: Surveillance	Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Low			
HDS(IPC)S.2008	Criterion 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.	PA Low	The service was noted to have two outbreaks this year. From 4 – 15 February a GI outbreak in the rest home resulted in 19 residents and six staff affected. From 4 – 21 July and 31 July – 19 August a GI outbreaks resulted in 22 residents in the rest home affected and 11 residents in the dementia unit. Outbreak summary reports and outbreak management meetings were held. Meeting minutes reviewed around outbreak management	Ensure meeting minutes identify follow through, actions taken, sign off and outcome.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				lacked actions/resolution and sign off		

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 1.1.9: 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 (two hospital, two rest home, two dementia) all confirmed that they are always informed when their family members health status changes.

A sample of incidents forms reviewed from October (14 dementia, nine rest home, six hospital) identified that 28 of 29 incident forms evidenced that family were contacted. One family requested only being informed of serious incidents.

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 1.1.13: 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, three verbal: In the rest home, seven written: In the dementia; two verbal, one 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 11 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.</p>

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.

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

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

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 Hilda Ross is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital level care for up to 158 residents, including 20 certified serviced apartments. Occupancy is 67 rest home residents, 43 hospital and 40 residents across the two 20-bed secure dementia units (the units are run as separate units with a shared open-plan office between). There are eight rest home residents in the serviced apartments. This audit also included verifying the rest home wing of 28 beds to be suitable for providing rest home or hospital level care.

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.

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 village manager and clinical manager has maintained at least eight hours annually of professional development activities related to management.

The service has in place a village manager (in the role since March 2013). She has worked in aged care since 1990 and was previously assistant manager. She is supported by an experienced aged care clinical manager (in the role for 10 weeks) with a post grad cert in gerontology.

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

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): <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: FA
Evidence: <p>Hilda Ross 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 Hilda Ross at the onsite monthly RAP meetings and weekly management meetings.</p> <p>Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with five registered nurses, an enrolled nurse and nine 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.</p> <p>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. The annual 2013 resident survey completed September and they are awaiting the results. A review of 2012 survey identified two main issues around food and complaints. Quality actions were established and implemented around those issues and a review of resident meetings identify an increased satisfaction.</p>

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. Hilda Ross also provides a six monthly comparative summary report that includes recommendations for residents and staff and training conducted. 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 (link improvements 3.5.7). d) Health and safety is addressed through the two monthly health and safety, 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). Quality improvement plan implemented for medication errors October 2013. 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. 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.

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: 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 1.2.4: 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 Low
Evidence: <p>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.</p> <p>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 six monthly periods from which to identify trends and improvements. However, improvements are required around analysing incidents further to identify opportunities for improvement. 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 an indicators from the "Standard on safe indicators in aged care".</p> <p>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 (14 dementia, nine rest home, six hospital) identified that all 29 incident forms were fully completed and included registered nurse assessment.</p> <p>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</p>

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 Low
Evidence: A sample of incidents forms reviewed from October (14 dementia, nine rest home, six hospital) identified that all 29 incident forms were fully completed and included registered nurse assessment.
Finding: A review of incident stats across 2013 identified that pressure areas were high for April (7) May (6) and June (6) in the hospital. No corrective actions were established. Incident and accident analysis has been completed monthly but lacks detail/trends and corrective actions. However, improvements to incident and accident analysis were noted from August 2013.
Corrective Action: Ensure analysis of incidents includes documented/implemented corrective actions at a facility level to minimise further incidents
Timeframe (days): 60 (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. Eight staff files were reviewed. All had completed reference checks, orientation and up to date appraisals. Hilda Ross 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 maintenance. 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 34 training sessions. A review of staff training records identified low-average attendance; however this is also supported by staff comprehension surveys at least two annually. The management team have established a corrective action around increasing staff attendance to training.

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 27 caregivers in the dementia unit, 12 have completed the required dementia standards, and two caregivers are in the process of completing. Four are new and nine are currently enrolled to commence.

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

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. .

In the serviced apartments there is a coordinator every morning 0800 – 1630, another caregiver 0700 -1300 and a caregiver1630 – 2100.

Across the two dementia units (20 residents in each) there is a registered nurse rostered across seven morning shifts. There is a separate roster per dementia unit.

There is a caregiver rostered in each unit overnight.

There is a hospital coordinator (RN) and another RN rostered across each shift including the morning shift.

In the rest home there is currently a rest home coordinator (RN) and another RN rostered in the morning across seven days. There is a draft roster for the rest home extension wing to manage swing beds (28). The roster covers and increase in hospital residents for five hospital and 10 hospital and so on.

Interviews with eight caregivers (three hospital, three rest home, two dementia, and one serviced apartment coordinator) confirmed staffing levels were satisfactory.

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.)*

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 1.3.3: 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:

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy.

The nursing care assessment and service delivery policy and nursing care assessment and planning interventions policy describes the responsibility around documentation.

Wound care folders were evidenced in all areas and assessments are signed by a registered nurse. Activity assessments and activities care plans have been completed by the activity therapists.

There is a continuum of service delivery policy that includes guidelines for a) nursing care assessment, b) planning care interventions, c) service delivery/interventions, and d) evaluation and care plan review. Timeframes are identified for assessment, initial care plan, long term care plan and evaluations. Staff were familiar with the timeframes and files reviewed were overall kept up to date.

D16.2, 3, 4; An assessment and initial care plan is completed within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. Nine resident files were reviewed (three from the rest home including one from a serviced apartment, three from the dementia unit and three from the hospital). All nine files the initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe.

D16.5e; Medical assessments were documented in all nine files within 48 hours of admission. Three monthly medical reviews were documented in six of nine files by general practitioner (link 1.3.6.1). It was noted in these six of nine resident files reviewed identified that the GP has assessed the resident as stable and is to be seen three monthly, three files identified a monthly review. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

Assessment tools completed on admission include a) pressure area risk assessment, b) skin integrity, c) continence, d) mobility, e) falls risk, f) cultural assessment and nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a duty handover supplement document which is completed for each shift that lists staff allocations, notes any residents requiring any special observations or needs and also advises of who is on call and who is the designated fire warden for that shift. There are two in house GP's involved with the service that visit twice weekly each. An experienced service coordinator is responsible for residents in the serviced apartments. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Nine files (three from the rest home including one from a serviced apartment, three from the dementia unit and three from the hospital) reviewed evidence this is occurring. This is an improvement since the previous audit. A registered nurse completes a weekly review in the progress notes every week in all areas. A weekly management meeting provides an opportunity to discuss any clinical issues. There is evidence in both the activities plans and the care plans of all nine files sampled of families having been involved in care planning and family suggestions/information being included in care plans and activity plans. This is also an improvement since the previous audit.

The physio visits daily and a physio assistant provides physio support 15 hours a week as directed by the physio.

One GP interviewed stated that the service provides a good standard of care and that there is good communication between him and the registered nurses.

Tracer Methodology rest home:

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

Tracer methodology dementia unit:

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

Tracer methodology hospital:

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: <p>Nine files were reviewed: There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality. Each area of the care plan includes: problems/needs, objectives and interventions. Overall three of the nine files reviewed reflected current needs. Identified areas of need including MRSA, falls risk management; pressure area risk management and weight loss do not have corresponding interventions in care plans. This is a previously identified shortfall that has not yet been addressed. Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as speech language therapist, physiotherapist, podiatrist, dietitian and MHSOP. Resident medications and medical status are reviewed one to three monthly by the general practitioners. Activity therapists maintain activity assessment/care plans and evaluation in residents file. There are specific physiotherapy progress notes.</p> <p>D16.3k: Short term care plans are in use for changes in health status with two exceptions. This is an area requiring improvement. D16.3f; Nine resident files reviewed identified that family were involved.</p>

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: PA Moderate
Evidence: Nine files were reviewed: There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality. Each area of the care plan includes: problems/needs, objectives and interventions. Overall three of the nine files reviewed reflected current needs.
Finding: (i) Six of nine care plans sampled do not have interventions relating to all areas of need. Examples include MRSA, falls risk management, pressure area risk management and weight loss. (ii) One resident in the dementia unit who has a possible delirium and one resident in the hospital with reddened areas in the groin requiring creams do not have short term care plans relating to these needs.
Corrective Action: Ensure that all areas of identified need have related interventions in care plans. (ii) Ensure that short term care plans are used to address short term needs.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Nine resident files were reviewed (three from the rest home including one from a serviced apartment, three from the dementia unit and three from the hospital).

Of the nine files reviewed, four of those residents were interviewed and all four reported their needs were being appropriately met. 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. Care plans were current and family were invited to attend review meetings (correspondence noted in files reviewed). Interview with five registered nurses (two from the hospital, one from the dementia unit, one from the rest home and one rest home coordinator) verified involvement of families in the care planning process.

The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs in three of nine files sampled (see CAR 1.3.5.2), and goals/objectives. There were short term care plans in four of the files reviewed (see also CAR 1.3.5.2).

One resident in the hospital has her only functioning hand bandaged to prevent her removing her naso gastric tube. There has been no restraint assessment completed or plan developed.

Two residents in the dementia unit have had weight loss of in excess of 10 kg between February 2013 and September 2013.

Neither has been referred to a dietitian and one does not have weight loss addressed in the care plan. The other does not have current interventions (fortisip) addressed in the care plan. One of these residents is prescribed TDS complain but food and fluid recording charts show she is not receiving this TDS. These are areas requiring improvement.

Six files showed a link between short term care planning and wound management plans.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for 42 wounds (some residents have multiple wounds) including two pressure areas. Nine of 42 wounds have not always been reviewed in the stated timeframes. In most cases this is for minor wounds with a delay of one to two days on one to two occasions. One skin tear scheduled to be reviewed every third day had a delay between reviews of seven days. This is also an area requiring improvement.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

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 Moderate

Evidence:

Nine resident files were reviewed (three from the rest home including one from a serviced apartment, three from the dementia unit and three from the hospital).

Of the nine files reviewed, four of those residents were interviewed and all four reported their needs were being appropriately met. 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. Care plans were current and family were invited to attend review meetings (correspondence noted in files reviewed). Interview with five registered nurses (two from the hospital, one from the dementia unit, one from the rest home and one rest home coordinator) verified involvement of families in the care planning process.

The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs in three of nine files sampled (see CAR 1.3.5.2), and goals/objectives. There were short term care plans in four of the files reviewed (see also CAR 1.3.5.2).

Six files showed a link between short term care planning and wound management plans.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

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.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for 42 wounds (some residents have multiple wounds) including two pressure areas.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Finding:

(i) One resident in the hospital has her only functioning hand bandaged to prevent her removing her naso gastric tube. There has been no restraint assessment completed or plan developed. (ii) Two residents in the dementia unit have had weight loss of in excess of 10 kg between February 2013 and September 2013. Neither has been referred to a dietitian and one does not have weight loss addressed in the care plan. The other does not have current interventions (fortisip) addressed in the care plan. One of these residents is prescribed TDS complan but food and fluid recording charts show she is not receiving this TDS. (iii) Nine of 42 wounds have not always been reviewed in the stated timeframes. In most cases this is for minor wounds with a delay of one to two days on one to two occasions. One skin tear scheduled to be reviewed every third day had a delay between reviews of seven days.

Corrective Action:

(i) Ensure that all residents using restraint have a documented assessment and plan around this. (ii) Ensure weight loss is appropriately managed including care plan documentation, dietitian referrals and residents receiving prescribed supplements. (iii) Ensure that all wounds are reviewed within stated timeframes.

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 six activity coordinators (one in the serviced apartments, one across the two dementia units, one in the rest home extension, one in the rest home, one in the hospital and one to cover any leave). There is also assigned lounge staff caregivers that supervise and provides activities to the residents in the special care units. 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 printed in large print on A3 paper and are displayed on notice boards around the facility.

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A 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 includes an activities assessment, 'your life experiences', Next of kin input into care and an activities care plan. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. This is an extremely well designed and comprehensive programme that meets the needs of all consumers.

This is a comprehensive programme that meets the needs of all consumers. The programme is evaluated and can be individually tailored according to resident's needs. There are separate programmes in the rest home, the hospital, the serviced apartments and the special care unit and from time to time residents in the special care units join activities in other areas.

The activity team described the implementation of the 'Spice of Life', a resident focused programme to enable the village to support residents achieve self-setting goals. Residents are able to participate in community activities as well as activities in the service itself. There is a resident choir and a knitting group.

The activities programme is developed for a month and a copy of the programme is kept in each resident's bedroom, in and on notice boards thought out the facility. Activities include (but not limited to): outings, triple A exercise, programme, music, crafts, shopping, happy hour, reading, and quizzes.

The triple A (Active, Ageless, Awareness) exercise programme was designed by the Ryman group and includes chair exercises for less active residents and more active exercise programme for mobile residents and serviced apartments. Residents were observed enjoying a triple A session. There are different levels of the programme depending on the mobility level of the residents.

Resident meetings are held in the hospital and rest home bi-monthly and feedback to activities is also provided at the meeting

All 11 residents (eight from the rest home and three from the hospital) and six family members (two from the hospital, two from the rest home and two from the special care units) interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed at the time of 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: <p>The evaluation and care plan review policy require that care plans are reviewed six monthly. The Vcare evaluation template describes progress against every goal and need identified in the care plan (sited). Short term care plans are well utilised in the rest home, hospital, and dementia unit (see CAR 1.3.5.2 around two exceptions). Any changes to the long term care plan are dated and signed. Nine care plans reviewed (three from the rest home including one from a serviced apartment, three from the dementia unit and three from the hospital) included handwritten updates to the plan as needs have changed (also link 1.3.6.1). Short term care plans were cited for wounds, weight loss, UTIs, poor appetite, gastric infection, and URTI and eye infections. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.</p>

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.12: 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: PA Moderate

Evidence:

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN in the hospital, dementia unit, dementia unit, rest home and rest home extension. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications. Medication administration was observed at lunch time in the hospital. Medications and associated documentation is kept on the medication trolley in locked treatment rooms in the four areas and in a locked cupboard in the serviced apartments. All medication sighted was noted to be within date. This is an improvement since the previous audit. However, there is one bottle of open eye drops in the serviced apartment area and two bottles in the rest home extension that have not been dated when they were opened and this is a previously identified issue that has not yet been addressed.

RN's in the hospital and senior caregivers/RN in the rest home/dementia unit deemed competent are responsible for administering medication. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. Controlled drugs are stored in a locked cabinet inside a locked treatment room in the rest home, the hospital and the dementia unit. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly. This is an improvement since the previous audit. Medication fridges are monitored weekly.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies are on all the drug charts. All senior caregivers/RNs administering medication complete a medication package. An annual medication administration competency is completed of each staff member. Medication training and competencies last occurred in June 2013. Five of 18 medication charts sampled have at least one dose of regular medication that has

not been signed as administered. This is a previously identified issue that has not yet been addressed.

There is a self-medicating resident's policy in place. A self-medication assessment checklist is available and has been completed and reviewed six monthly for the two residents who self-administer.

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. This is an improvement since the previous audit.

D16.5.e.i.2; Eighteen medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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: PA Moderate

Evidence:

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN in the hospital, the two dementia units, rest home and rest home extension. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications. Medication administration was observed at lunch time in the hospital. Medications and associated documentation is kept on the medication trolley in locked treatment rooms in the four areas and in a locked cupboard in the serviced apartments. All medication sighted was noted to be within date. This is an improvement since the previous audit.

Finding:

(i) Five of 18 medication charts sampled have at least one dose of regular medication that has not been signed as administered. (ii) There is one bottle of open eye drops in the serviced apartment area and two bottles in the rest home extension that have not been dated when they were opened.

Corrective Action:

(i) Ensure all medications are documented as administered as prescribed. (ii) Ensure all eye drops are dated when they are opened.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <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:

All kitchen staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller and a pantry. The menu is designed and reviewed by a registered dietitian at an organisational level. There is a three monthly rolling menu. All meals are cooked in the main kitchen and are transferred to the rest home, hospital and dementia units in insulated containers. Trays of food are then removed from the insulated transfer boxes and placed in warmed bain maries. Caregivers serve the food from bain maries in kitchenette areas in each unit. There are also snacks available over 24 hours for residents. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed by ECOLAB. 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. Food temp audit October 2013 showed 100. Residents with special dietary needs have a nutritional profile completed on admission. This is reviewed six monthly as part of the care plan review. Changes to resident's dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the kitchen notice board, which is able to be viewed only by kitchen staff. E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours.

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

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

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 1.4.2: 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:

Legislation and regulatory requirements appear to be met for local authorities and the MoH. Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness, which expires on 8 May 2014. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2013. Health and Safety meetings include maintenance and preventative maintenance. Electrical testing occurs two yearly. Hoists are checked annually and all medical equipment is calibrated at this time also. Hot water is checked three monthly and records show these are maintained within safe limits.

The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. Hand rails are available around the hall ways. There is adequate space around the facility for storage of mobility equipment.

There is an outside area with shade and seating that is observed to be well maintained with paths and handrails.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

The rest home extension wing was verified as suitable to provide rest home or hospital care. The rooms and ensuites are large enough to manage mobility equipment.

There is communal mobility toilets. The lounge and dining area is adequately size for increase in lazy boys or mobility equipment.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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>

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 three enablers (bedrails) in use and three restraints (three bedrails). One enabler file was reviewed and included consents and assessments.

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 2.2.4: 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: PA Low

Evidence:

Restraint evaluation is completed. Evaluations were not completed regularly in the two files reviewed. Family members interviewed say that they are involved in and communicated with about their family members' care.

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: PA Low

Evidence:

The service has a process to document evaluation of restraint every three months. The restraint process considers the items listed in a) - k).

Finding:

In the two restraint files reviewed evaluations had not been completed on a regular basis

Corrective Action:

Ensure evaluations are completed as per timeframes identified via the assessment process

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

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

Standard 3.5: 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: PA Low

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. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.

The IC Officer (rest home coordinator) 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. The service was noted to have two outbreaks this year. From 4 – 15 February a GI outbreak in the rest home resulted in 19 residents and six staff affected. From 4 – 21 July and 31 July – 19 August a GI outbreaks resulted in 22 residents in the rest home affected and 11 residents in the dementia unit. Outbreak summary reports and outbreak management meetings were held. Meeting minutes reviewed around outbreak management lacked actions/resolution and sign off.

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: PA Low
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.
Finding: The service was noted to have two outbreaks this year. From 4 – 15 February a GI outbreak in the rest home resulted in 19 residents and six staff affected. From 4 – 21 July and 31 July – 19 August a GI outbreaks resulted in 22 residents in the rest home affected and 11 residents in the dementia unit. Outbreak summary reports and outbreak management meetings were held. Meeting minutes reviewed around outbreak management lacked actions/resolution and sign off
Corrective Action: Ensure meeting minutes identify follow through, actions taken, sign off and outcome.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)