

# Jane Winstone Retirement Village Limited

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Current Status: 25 February 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Partial Provisional 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 Jane Winstone is a modern facility that is part of a wider village. The service currently provides rest home level care for up to 59 residents (including 20 serviced apartments approved for rest home level care). Occupancy during the audit was 33 residents in the rest home and five residents in the serviced apartments. This partial provisional audit was completed to assess the appropriateness and preparedness of the service to provide hospital level care. The current rest home of 39 resident rooms was assessed as suitable to provide rest home or hospital level care.

The audit identified the facility, staff roster, equipment and processes are appropriate for also providing hospital (geriatric and medical level) care and in meeting the needs of the residents.

The service has addressed one of two shortfalls identified under service delivery in the previous audit around progress reporting and short term care plans (STCPs). Further improvements continue to be required around medication documentation.

This audit also identified improvements required around care planning and ensuring registered nurses are in place to cover all shifts with the introduction of hospital residents.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## 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

<b>Legal entity name:</b>	Jane Winstone Retirement Village Limited
<b>Certificate name:</b>	Jane Winstone Retirement Village Limited
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Jane Winstone Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 24 October 2014 <b>End date:</b> 24 October 2014
<b>Proposed changes to current services (if any):</b>	

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	43
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## Audit Team

<b>Lead Auditor</b>	XXXXXXXXXX	<b>Hours on site</b>		<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXXXX	<b>Total hours on site</b>	7.5	<b>Total hours off site</b>	5
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	15	Total audit hours off site	12	Total audit hours	27
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Number of residents interviewed		Number of staff interviewed		Number of managers interviewed	
Number of residents' records reviewed		Number of staff records reviewed		Total number of managers (headcount)	
Number of medication records reviewed		Total number of staff (headcount)		Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

## Declaration

I, XXXXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited 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)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 27 November 2014

## Executive Summary of Audit

### **General Overview**

Jane Winstone provides hospital and rest home level care across 38 beds in the care centre. There are also 20 serviced apartments approved to provide rest home level care. On the day of audit there were four hospital and 39 rest home residents including three rest home residents in the serviced apartments, and three respite residents.

The village manager has been in the role since October 2013 and has a health management background. The village manager is supported by a full-time clinical nurse manager who was appointed in June 2014 to support the commencement of hospital services. She is a registered nurse who works full time and is supported by a 24/7 registered nurse team. There is a comprehensive orientation programme and ongoing education plan.

The four shortfalls identified in the previous audit relating to adverse events, allied health instructions, care planning and medications have all been addressed. This audit identified improvements required around documentation of interventions, review of activity plans and care plans at the same time, enabler consent and documentation and aspects of medication prescribing.

### **Outcome 1.1: Consumer Rights**

Policies are implemented to support residents' rights which include ensuring staff communicate with residents and relatives in an appropriate manner that respects the rights of residents. Staff practice open disclosure. Complaints processes are implemented and complaints and concerns are actively managed and well documented.

### **Outcome 1.2: Organisational Management**

Jane Winstone participates in the Ryman accreditation programme, which is overseen by head office. There are facility-specific quality goals established for 2014 and staff are guided by a range of policies and associated procedures. The service has addressed the previous shortfall related to the recording of adverse events. Human resource practices are overseen by head office. There are documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. There is a comprehensive orientation and induction programme in place that provides new staff with relevant information for safe work practices. A training plan for 2014 is in place that includes relevant clinical care. Registered nurses are supported to maintain their professional competency.

### **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 provide 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. The previous shortfall around the documentation of allied health instructions and interventions to reflect current falls and pressure area risks has been addressed. This audit identifies an improvement around the documentation of interventions to reflect the resident's current needs.

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 rest home and hospital residents. Spiritual and cultural preferences and needs are being met.

Education and medicines competencies are completed by all staff responsible for administration of medicines. Medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, allergies and special instructions for administration. The previous audit findings around aspects of medication documentation and photo identification has been addressed. This audit identified an improvement around prn indications for use and initially medication chart errors.

Food services and all meals are provided on site. Resident's individual food preferences and dislikes are not known by kitchen staff and those serving the meals. There is dietitian review of the menu. All staff are trained in food safety and hygiene.

### **Outcome 1.4: Safe and Appropriate Environment**

The building has a current warrant of fitness. A reactive and preventative planned maintenance schedule is in place. Clinical equipment is calibrated and checked annually. Electrical testing occurs annually.

### **Outcome 2: Restraint Minimisation and Safe Practice**

There are comprehensive policies and procedures that meet the restraint standards. There is a restraints co-ordinator (registered nurse) with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and ongoing. There are two residents with restraints in use and one residents with an enabler in use. There is an improvement required around enabler consents, and clearly defining restraint or enabler use on resident care plans and associated documents.

### Outcome 3: Infection Prevention and Control

The infection prevention and control programme is managed by the infection prevention and control officer who is the clinical manager. She is directly responsible to the village manager. The surveillance programme is included in the Ryman accreditation programme, which is reviewed annually. The infection prevention and control committee, which is part of the health and safety committee, meets bimonthly. An individual infection report form is completed for each infection. Thereafter a monthly infection summary is prepared and then discussed at the combined bimonthly IPC and Health and safety meeting. A six monthly comparative summary is completed and forwarded to head office. Infection rates are benchmarked against other Ryman facilities. There have been no major outbreaks of infection within the facility since the previous audit.

### Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	2	1	0	0
Criteria	0	37	0	2	1	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	33
Criteria	0	0	0	0	0	0	0	61

### Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	PA Low	(i) There is no short term	Ensure interventions are	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		care plan in place for the management of a sacral pressure area for a hospital resident. (ii) There is no documentation in the care plan for a resident with risk of choking as identified in progress notes.	documented in the care plans to reflect the residents current needs.	
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			
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	a) There are no indications for use on three out of 10 medication charts reviewed for XXXXXX. b) Prescription errors (two) and signing errors (two) that have been crossed out do not have a date or signature.	a) Ensure all prn medications have an indication for use prescribed. b) Ensure all errors are crossed with a single line, dated and signed.	60
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 2.1.1.4	The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer	PA Low	The care plans of the three residents (two with restraint, one enabler) does not clearly identify if	a) Ensure the resident is able to voluntarily choose and sign for enabler use. b) Ensure the care plan	90

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
		with the intention of promoting or maintaining consumer independence and safety.		enabler or restraint is in place.	clearly identifies enabler or restraint use.	

## Continuous Improvement (CI) Report

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>

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

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## 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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

#### **Attainment and Risk:** FA

#### **Evidence:**

Staff actively promote effective communication with residents in accordance with Ryman's values and policy (confirmed in discussions with six of six residents (i.e., three rest home and three hospital).and two of two relatives (one rest home and one hospital)). Information is provided on entry and open disclosure is practiced. Management contact relatives and discuss matters in an open manner consistent with the open disclosure policy. The incident/accident forms have a section to indicate if family/whanau have been informed (or not) and the name of the person informed. Staff record contacts with family/whanau on the family/whanau contact record.

Incident/accident forms once completed are stored in individual resident records. These identify whether next of kin were notified or not and if not the reason why they were not contacted when the incident occurred. Relatives are notified as soon as staff become aware that a resident's health has changed significantly (confirmed in discussions with two of two relatives (i.e., one rest home and one hospital)). Residents are orientated to the service on admission. Informed consent processes are in place. Residents have access to interpreter services which includes access to the Blind Foundation and the Hearing Association.

Each resident or their nominated representative is provided with an admission agreement (which is a template document) and a copy is stored onsite in the administration office. The information pack is given on initial visit and is easy to read. The admission agreement is explained by the village manager and if needed the information can be read to residents and is available in large print. In times of emergency when relatives are not available the facility will transport residents to their general practitioner.

Staff receive on-going education regarding open disclosure (last provided 23 April 2013).

A 13.1 & D 13.2: Each resident or their nominated representative is provided with an admission agreement and a copy is stored onsite in the administration office.

A 14.1: The Admission Agreement for permanent residents (sighted) specifies included services.

D 11.3: The information pack is easy to read and if needed the information can be read to residents and is available in large print.

D12.1 & D12.3a: 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.

D 12.4 & D12.5: Residents (and/or their representatives) are informed in the agreement of their right to apply for a review of their means assessment

D16.1b.ii: Residents and family are informed in the Agreement prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Relatives are notified as soon as staff become aware that a resident's health has changed significantly (confirmed in discussions with the clinical manager and confirmed in discussions with two of two relatives (i.e., one rest home and one hospital)).

D 16.5e, iii: On-call emergency services are available and the costs are met.

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

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

#### **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:**

The service complaint management policies exist to guide practice. The service has in place a complaints policy and procedure that aligns with Right 10 of the Code of Health and Disability Consumers' Rights (i.e., the Code). Complaints management is an integral part of the quality and risk management system. The entry pack includes complaints information and complaints forms are also available throughout the facility. The complaints process is also reinforced at resident meetings.

A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on VCare.

Since the village manager was appointed in Oct 2013 there have been eight complaints received and two of the eight were found to be justified following investigation. Both justified complaints related to standards of care provided. No complaints required reporting to external agencies.

The residents meeting and staff meeting minutes include discussions of previous identified opportunities for improvement.

Staff receive on-going education on consumer complaints management (last provided 22 May 2014 to 28 staff) and consumers rights (last provided 24 April 2014 to nine staff).

D13.3h: Information on the complaints process is provided to residents and relatives at entry to the service (confirmed in discussions with six of six residents (i.e., three rest home and three hospital).and two of two relatives (i.e., one rest home and one hospital)). The procedure is also prominent around the facility on noticeboards.

**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:**

Jane Winstone provides a total of 39 dual purpose beds in its care centre. There are also 50 serviced apartments on site of which 20 beds are approved to provide rest home level care in the serviced apartments. The care centre is located within a wider retirement village. Ryman Healthcare is governed by a Board of Directors. There is a documented "purpose, values, scope, direction and goals policy". The CEO and senior management work from a head office which is located in Christchurch. Ryman Healthcare's overall mission is defined in the Ryman Healthcare philosophy document. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the Ryman Accreditation Programme (RAP) that includes a schedule across the year for the following areas: a) RAP Head Office, b) general management, c) staff development, d) administration, e) audits/infection control/quality/compliance/health and safety and f) Triple A/activities. Each facility has their own specific RAP objectives and for Jane Winstone in 2014 this includes; a) to ensure full compliance with new and existing staff induction timeframes, b) to raise awareness and the profile of Jane Winstone in the community, c) to improve dining experiences of serviced apartment residents, d) to enhance the variety of activities, e) to improve staff morale, f) to ensure successful service delivery to hospital level residents.

There are comprehensive policies/procedures to provide rest home care, and hospital- level care (geriatric and medical).

The village manager has been in the role since October 2013. She has a health management background. She has completed eight hours of specific management education within the last 12 months, which included her orientation with Ryman and attendance at the annual Ryman manager's conferences.

The village manager is supported by a full-time clinical nurse manager who was appointed in June 2014 to support the commencement of hospital services. She is a registered nurse who works full time and is supported by five other registered nurses who work a mix of hours.

The management team is supported by the Ryman management team including regional manager who visits the facility once a month on average. The management resource manual includes a number of documented responsibilities of the village manager including a list of reporting requirements. There is a village manager's job description that includes authority, accountability and responsibility including reporting requirements. Ryman Manager's complete a Leadership and Management courses (an initiative by Ryman) that includes a number of modules. Management development programme includes self-directed learning packages.

D17.4 (b) (i): The facility is managed by an appointed manager who has experience in management and the health and personal care of older people and who maintains at least eight hours annually of professional development related to managing a hospital facility.

D17.5: A separate clinical manager is appointed to assist the village manager, as the village manager does not hold a registered nursing qualification.

**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 1.2.3: 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:**

Jane Winstone has a well-established quality and risk management system that is directed by head office and documented in the Ryman Accreditation Programme (RAP) Each facility has its own facility specific plan that links to the overall plan. 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 Jane Winston at the onsite monthly RAP meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with six of six care assistants (who cover all shifts) and review of meeting minutes demonstrate staff awareness and involvement in quality assurance and improvement activities. The monthly full facility RAP meeting included discussion of 2014 quality goals. Resident meetings are held two monthly and relatives six monthly and minutes are kept. Annual resident and relative surveys are completed. The last resident survey was completed in May 2014. Results are benchmarked against other Ryman facilities. Quality Improvement Plans (QIP's) are completed to address any issues raised. Benchmarking occurs throughout Ryman facilities. Quality improvement plans (QIP) are raised as a result of identified shortfalls. Reporting QIP's to head office ensures monitoring of any service delivery shortfalls. Staff are able to access reports from VCare which demonstrate quality data over time (reports sighted). Staff are proactive around involving residents and relatives in the service. Risk management, hazard control and emergency policies and procedures are in place.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. There is a document control system in place and any changes or new documents require head office approval and distribution. Obsolete documents are removed. The monthly RAP schedule includes signing off that manuals have been reviewed and documents have been replaced as appropriate. The management resource manual describes the management of policies and procedures and documentation control.

D19.2g: Fall 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. Residents are referred to physiotherapists as the need arises.

D19.3 There are implemented risk management and health and safety policies and procedures in place including accident and hazard management.

D19.4 (b): There is a quality improvement plan in place, which is the RAP.

D19.4 (d): Performance is monitored and evaluated against the RAP including satisfaction surveying, internal and external quality reviews

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

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

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

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

**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):** *(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:** FA

**Evidence:**

All adverse events are recorded in accordance with the accident/incident reporting policy and reported according to policy. Incidents and accidents are documented by staff when they occur. Once the form has been processed and the data entered into VCare the original completed form is filed in each resident's clinical record. Staff document all incidents and accidents and these are processed by management and results are reported. This is an improvement from the previous certification audit when discrepancies were evidenced. Incident /accident forms sighted in residents' clinical records were fully completed and follow-up was documented.

Staff receive feedback through meetings. Improvements are made to the service as and where appropriate. QIP's are developed to implement improvements. Adverse events are linked to the organisation's benchmarking programme and the data are used for comparative purposes. Minutes of the monthly RAP (full facility) committee meetings, two monthly health and safety meetings and weekly management meetings reflect a discussion of incidents and accidents and any actions taken. Six monthly comparative reviews identify further facility improvements required.

There is an open disclosure policy that identifies the communication responsibilities to inform family/relatives of the event and actions taken. Incident/accident forms have a section to indicate if next of kin have been informed (or not) of the event. Discussion with two of two family members informed communication is good and that they are informed of any change in health status of their family member.

Staff receive on-going education regarding the reporting of incidents, accidents and hazard management (last provided 21 August 2014 to 28 staff).

Staff can describe the incident reporting process and their role (confirmed in discussions with six of six care assistants, two of two registered nurses and the clinical manager).

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

D19.3c: Management is aware of their reporting obligations to report serious adverse events to the relevant agencies (confirmed in discussion with the village manager).

**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:** 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 1.2.7: 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:**

Human resource policy and practices are overseen by head office staff and senior management. A review of five of five staff employment records (i.e., the clinical manager, two registered nurses and two care assistants) showed that employment records were consistent with Ryman policy. There are documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Additional role descriptions are in place (eg, for the infection prevention and control coordinator and the restraint coordinator).

The village manager ensures that all health practitioners providing services to residents hold current professional qualifications. Qualifications are validated on appointment, including health practitioner registrations and relevant scopes of practice. A register of registered health practitioners practising certificates is maintained within the facility (sighted). This includes the registered nurses, the current general practitioners' registration and the pharmacist. The podiatrists practising certificates are held in their contract records.

The village manager oversees the recruitment process in consultation with the clinical manager. This process operates in accordance with Ryman policies.

All newly appointed staff receive a comprehensive orientation/induction programme that provides them with relevant information for their role. The programme is tailored specifically to each position such as (but not limited to) care assistants, senior care assistants, registered nurse, and clinical manager. The orientation/induction training for care assistants, on completion, is equivalent to foundation level two NZQA. There is a specific employees' induction manual. Written questionnaires are completed for specific areas (eg, culture, complaints, advocacy and informed consent). Following orientation and induction care assistants are encouraged to enrol in the ACE programme to achieve ACE core, and ACE advanced, as appropriate, if not achieved prior to employment. The facility employs an ACE and inductions officer for eight hours a week to oversee the care assistant training programme. Currently all except two care assistants (i.e.: 14 of 16 care assistants) have completed or are in the process of completing ACE Foundation level and eight of the 16 hold ACE Advanced qualifications. The registered nurses are supported to maintain their professional competency by discussing training needs at annual appraisals and through the two monthly journal club. There are clinical educators employed by head office who provide clinical support at facility level.

Staff training records are maintained. Training needs for staff are identified and discussed during the annual performance appraisal process.

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

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

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

**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:**

The facility is staffed according to policy with flexibility to match resident acuity. The policy identifies the rationale for determining staffing levels and skill mix for safe service delivery.

D17.4a-d: Currently the facility is staffed by registered nurse's 24 hours a day, seven days a week. The team of registered nurses are supported by the clinical manager who is employed full-time and is a registered nurse with a current practising certificate. She is actively involved in care management. Both the village manager (non-clinical) and/or the clinical manager are typically on site during the working week. The clinical manager typically works Sundays to Thursdays. The village manager typically works Monday to Friday. There are at least two care staff on duty 24 hours a day, seven days a week.

The serviced apartments are staffed by a senior caregiver from 8 am to 4.30 pm each day plus two other caregivers (one works 7-3 and the other works 7.30 to 11am daily). There are two caregivers in the serviced apartments in the afternoon (one 4.30 to 9pm and the other 5pm to 7pm). The care centre oversees the apartments after 9pm.

The service has a number of general practitioners currently and there are plans to formally contract one of the GPs in the near future to provide a more comprehensive service.

### **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; D16.5ci; 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 service provides hospital and rest home level of care including rest home care in serviced apartments. The registered nurses (RN) 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.

D16.2, 3, 4; An initial assessment is completed within 24 hours and initial care plan within 48 hours of admission in five out of five resident files sampled (one hospital, four rest home – including one younger person and one respite care). The long term care plan is developed within three weeks in three of five resident files sampled (one hospital and two rest home). One rest home resident recently admitted has not been at the service three weeks. One resident is in for respite care.

The care plan is reviewed by the registered nurses at least six monthly in consultation with the resident/family/whanau. The long term care plans of the five resident files sampled (one hospital, three rest home and one rest home respite care) include allied health professionals involvement and instructions as applicable such as the wound nurse specialist, palliative care nurse and physiotherapist. This is an improvement since the provisional audit.

D16.5e; Medical assessments are documented in all four long term resident files within 48 hours of admission. The respite care file had a current general practitioner (GP) information letter. Three monthly medical reviews are documented in the three files (one hospital and two rest home) by the facility general practitioner. Residents may retain their own GP. One rest home resident is not due for a three monthly medical review. More frequent medical assessment/ review is noted occurring in residents with acute conditions as evidenced in the file of the hospital resident suffering transient ischaemic attacks. The facility GP is not available on the day of audit. The residents interviewed (three hospital and three rest home) state they are happy with the medical care they receive and are kept informed of their health status. The family members interviewed (one rest home, one hospital) stated they are kept informed on the residents health status and has the opportunity to meet with the GP during his rounds.

Six care assistants (across all services) interviewed could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Duty Handover sheets note any residents requiring any special observations or needs. Progress notes are maintained at least daily for rest home and each shift for hospital residents or more frequently as required.

A physiotherapist, dietitian, speech language therapist, continence and wound care specialist is available by referral. Allied health professionals maintain records within the resident file (sighted). The physiotherapist is involved in the multidisciplinary review (MDR) as relevant. Safe manual handling education for staff was last provided June 2014. There is a close liaison between the service and needs assessors, mental health services for the older person, palliative care services and the geriatrician as required.

Tracer methodology hospital resident;

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

Tracer methodology rest home resident recently admitted for palliative care:

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

**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:** FA

**Evidence:**

The outcomes of six monthly written evaluations and review of risk assessments in three of four long term resident files (one hospital and two rest home) are reflected in the long term care plans. One rest home resident has not been at the service six months. The previous finding at the partial provisional audit has been addressed.

### **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:** 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 Low

**Evidence:**

Five resident files were reviewed (three rest home, one respite care – rest home, and one hospital). Assessment tools completed on admission include a) waterlow pressure area risk assessment, b) three day continence diary, c) mobility assessment d) coombes falls risk e) mini nutritional assessment as applicable f) pain assessment g) wound assessment h) behaviour assessment and j) restraint/enabler assessment. Risk assessments are reviewed when there is a change to condition or at least six monthly. There is an improvement required around documentation of interventions to reflect the resident's current health status.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and treatment plan and evaluations are in place for five skin tears, two lacerations, one surgical wound, three minor wounds and four residents with leg ulcers. Photos have been taken and there is evidence of wound nurse specialist input into wound care management.

There are two residents with pressure areas (grade 2). Pressure area prevention strategies are included in the long term care plan. There is an improvement required around short term care plans. GPs are notified of all wounds and non-healing skin tears. Wound nurse specialist advice is readily available as required. Wounds, skin integrity and pressure areas in service was provided in September 2014.

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 clinical manager and two RN's interviewed. Continence management education was provided in August 2014.

Calibrated weighing chair scales are used to weigh residents monthly. Weight loss short term care plans are in use as evidenced which include drink supplements, food and fluid monitoring, frequency of weighing, GP/Dietitian notification. The resident dietary requirement is reviewed and a copy sent to the kitchen. A dietitian is available as required and notified for any weight loss of 2kg or more per month. Food and fluid monitoring charts are evidenced in use.

Short term care plans are available for use to document interventions for short term needs/changes to health. Relatives interviewed state they are kept informed of any changes to the resident's health.

### **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:**

Five resident files were reviewed (three rest home, one respite care – rest home, and one hospital). Residents interviewed (three rest home, three hospital) report their needs are being appropriately met. Relatives interviewed (one rest home, one hospital) state the needs of their relatives are being appropriately met and they are kept informed of any changes to health and interventions required. Risk assessments are reviewed when there is a change to condition or at least six monthly. There are examples of short term care plans in use to document interventions for short term needs/changes to health. However further improvements are required in this area.

**Finding:**

(i) There is no short term care plan in place for the management of a sacral pressure area for a hospital resident. (ii) There is no documentation in the care plan for a resident with risk of choking as identified in progress notes.

**Corrective Action:**

Ensure interventions are documented in the care plans to reflect the residents current needs.

**Timeframe (days):** 90 (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 two full-time activity co-ordinators and one part-time and one reliever that provide a separate Monday to Friday activity programme for the rest home/ hospital and serviced apartments. A company diversional therapist (DT) oversees the activity programmes. The activity co-ordinators attend Ryman workshops and on-site in-services. All hold a current first aid certificate. Two of the activity team have commenced training towards DT qualifications.

The programme is planned monthly and includes Ryman minimum requirements for the "Engage" programme. Activities programmes 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. One

of the activity co-ordinators has attended Triple A instructor training. Other activities such as; crafts, happy hours, movies, board games, word games, walks and open discussions are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. One on one time is such as sensory or reminiscing activities are spent with residents who are unable to actively participate in the activities. Residents in serviced apartments can choose to attend the serviced apartment or rest home/hospital activities.

Entertainers are scheduled weekly. Community visitors include guest speakers (diabetes nurse, museum speaker, and neurological society), school children, canine pet therapy and returned service association member, old time dancers and church visitors. Open church services are held weekly and residents are supported to attend their own churches. There are regular outings, scenic drives, cafes, shopping and library visits. There is an activity goal to hire a mobility van to ensure hospital residents who wish to go on outings have suitable transport provided.

The resident is assessed and with family involvement if applicable and likes, dislikes, 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'. The activity plan includes headings for comfort and wellbeing, outings, interests and family and community. A resident attendance list is maintained for activities, entertainment and outings. Resident meetings are held two monthly and family meetings six monthly. There is an opportunity to provide feedback on activities at the meetings and six monthly reviews. Resident and relative surveys also provide feedback on the activity programme.

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

### **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. Three of five resident files sampled (one rest home, one hospital) contained written evaluations completed six monthly. One rest home resident is on respite care and another rest home resident has not been at the service six months. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems.

D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated.

D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

### **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 for regular and PRN medications. Medication reconciliation is completed on delivery of medications and the signing sheet is signed by the RN checking the medications. Any discrepancies are fed back to the pharmacy. The two medication trolleys are kept in one locked medication room. Registered nurses and senior caregivers are competency assessed annually and responsible for administering medication. Medication education was completed in August 2014. RN's have not completed syringe driver training to date. Hospice provided palliative care support. Controlled drugs are stored in a controlled drug safe in medication room. There are weekly controlled drug checks. Standing orders are in use. There are three residents self-medicating who have been competency assesses. Medications are stored securely in their rooms. The resident self-medicating assessments are reviewed three monthly by the GP and RN. Self-medication is monitored by the RN on duty. All eye drops and ointments are dated on opening. Medication fridge temperatures are monitored weekly. Administration signing sheets reviewed are correct and complete. Two medication competent persons sign for the administration of controlled drugs. PRN medications administered have a date and time of administration recorded. PRN medication expiry dates are checked monthly. Emergency oxygen and suction is checked weekly. Blood sugar monitoring and pain monitoring charts are kept in the medication folder.

Individually prescribed resident medication charts are in use and this provides a record of medication administration information with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is legible, signed and dated. There is an improvement required around the prescribing of PRN medications and prescribing errors.

D16.5.e.i.2; All 10 medication charts reviewed charts have photo identification and an allergy status documented on the medication chart. Ten medication charts reviewed (eight rest home and two hospital) identified that the GP had seen the resident 3 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:**

Individually prescribed resident medication charts are in use and this provides a record of medication administration information with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is legible, signed and dated.

**Finding:**

a) There are no indications for use on three out of 10 medication charts reviewed for XXXXXXXX. b) Prescription errors (two) and signing errors (two) that have been crossed out do not have a date or signature.

**Corrective Action:**

a) Ensure all prn medications have an indication for use prescribed. b) Ensure all errors are crossed with a single line, dated and signed.

**Timeframe (days):** 60 (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):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

### **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:**

There is a cook and morning kitchen hand on duty each day. There is an evening kitchen hand to heat and serve the semi-prepared tea. The four weekly seasonal menu is designed and reviewed by a registered dietitian (March 2014) at an organisational level. The cook has on-line and email communication with the Hotel Services Manager at head office. All meals and morning teas are cooked on site. The hot meal is at midday with a lighter tea. The cook receives resident dietary information and needs from the RN and is notified of any changes to dietary requirements (vegetarian, moulded foods) or any resident with weight loss. The cook (interviewed) is able to describe high calorie foods offered for weight loss. Likes, dislikes and special diets are known. Alternative meals are offered for those residents with dislikes or religious preferences. Alternative meats are offered for pork and chicken meals. Menus are displayed. Meals are delivered in a bain mairé to the dining room. Meals to rooms are plated and covered with heat lids. Lip plates, sipper cups and special utensils are available for residents to promote independence with meals.

The service has a workable kitchen with a separate area for dishwashing, food preparation and cooking. The fridges and freezers temperature are recorded weekly. The dry goods area is tidy with all goods off the floor and dated. All foods in fridges are dated. End cooked temperatures on all meals are checked and recorded weekly. Staff are observed wearing correct personal protective clothing. Chemicals are stored in a locked cupboard within the kitchen. Cleaning schedules are maintained.

Six residents interviewed (three rest home and three hospital) are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys. The cook (interviewed) interacts with the residents during meal times (observed). 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.

D19.2: Food services staff have completed food safety and hygiene courses and chemical safety August 2014.

### **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 1.4.2: 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:**

The building holds a current warrant of fitness which expires on 17 March 2015. The service employs a full-time maintenance officer for the facility. Preventative and planned maintenance is carried out. Contractors are called in as required and there are 24/7 contractors available for essential services. Building maintenance is carried out when necessary and records maintained. Water temperatures are monitored. Medical equipment including hoists and chair scales are checked and/or calibrated annually next due July 2015. Annual electrical testing and tagging has been completed June 2014. The maintenance officer is a trained electrical tester.

The staff interviewed state they have adequate equipment to safely deliver cares including; lifting and standing hoists, sensor mats, electric beds, wheelchairs, pressure area mattresses and cushions, mobility aids and chair scales.

### 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.)*

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

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### 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:** PA Low

**Evidence:**

There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service had been restraint free up until July 2014. There are two restraints (bedrails) and one enabler in use for three hospital residents. There is an improvement required around consent for enablers. The restraint co-ordinator (RN) maintains a monthly restraint and enabler register is maintained.

The long term care plan (under safety/risk) includes the use of restraint/enablers, frequency of monitoring and required documentation. There is restraint monitoring guidelines in place. Risks known to be associated with the use of restraints/enablers (three files reviewed) are reflected in the care plan. There is an improvement around the identification of restraint or enabler in use.

Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the restraint approval and review process. Types of restraint have been approved for use by the restraints committee that meet six monthly.

Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education was provided in April 2014 by the clinical educator.

#### **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:** PA Low

**Evidence:**

There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service had been restraint free up until July 2014. There are two restraints (bedrails) and one enabler in use for three hospital residents. The restraint co-ordinator (RN) maintains a monthly restraint and enabler register is maintained. The long term care plan (under safety/risk) includes the use of restraint/enablers, frequency of monitoring and required documentation. There are restraint monitoring guidelines in place. Risks known to be associated with the use of restraints/enablers (three files reviewed) are reflected in the care plan.

**Finding:**

The care plans of the three residents (two with restraint, one enabler) does not clearly identify if enabler or restraint is in place.

**Corrective Action:**

a) Ensure the resident is able to voluntarily choose and sign for enabler use. b) Ensure the care plan clearly identifies enabler or restraint use.

**Timeframe (days):** 90 (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

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### **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:**

The surveillance policy states the routine/planned surveillance programme is organised and promoted via the Ryman accreditation programme calendar. The health and safety committee meet bimonthly and also act as the infection prevention and control (IPC) committee. Effective monitoring is the responsibility of the infection prevention and control officer who is the clinical manager. She is directly responsible to the village manager who in turn is responsible to the regional manager. An individual infection report form is completed for all each infection. Data is logged into VCare, which gives a monthly infection summary. This summary is then discussed at the bimonthly combined health and safety and infection prevention and control meetings. Three month and six monthly comparative summary of the data are completed and forwarded to head office. All meetings held at Jane Winstone include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Internal audits are completed for hand washing audit (last conducted April 2014-100%), housekeeping (March 2014-100%), linen services (March 2014-100%) kitchen hygiene (January 2014-100%). Infection rates are benchmarked across the organisation. The majority of infections at Jean Winstone in the 12 months from 1 October 2013 were urinary tract infections (ie, 57%). There have been no outbreaks of infection within the facility since the previous audit. Staff receive ongoing education regarding infection prevention and control (last provided 18 September 2014 to 31 staff) and outbreak management (last provided 24 June 2014).

#### **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.)*