Kiri Te Kanawa Retirement Village Limited

Current Status: 27 March 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

Kiri Te Kanawa Retirement Village is a Ryman Healthcare facility, situated in Gisborne. The care centre (hospital, rest home and six-bed dementia unit) on level one was opened November 2011. There are currently 52 residents in the care centre (19 hospital, 30 rest home, and three dementia) and five rest home residents in the 30 serviced apartments certified for rest home level care. The care centre extends over two levels. This partial provisional audit included verifying the 16-bed dementia unit situated on level two and the additional 12-bed rest home care centre on level two. When the new dementia unit opens (level 2); the current six-bed dementia unit (level one) will have the secure door removed and these beds will revert to hospital level care.

Ryman and Kiri Te Kanawa have been proactive in preparing for the special care unit and have developed quality objectives and strategy plans around the implementation of the unit.

The organisation completes annual planning and has comprehensive policies/procedures to provide rest home, hospital/medical and dementia level care. This partial provisional audit identified that the environment, draft rosters and processes are appropriate for providing increased dementia level care and increasing rest home resident numbers and in meeting the needs of the residents.

Improvements are required by the service are in relation weight loss management, pain monitoring and aspects of medication management.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Kiri Te Kanawa Retirement Village Limited
Certificate name:	Kiri Te Kanawa Retirement Village Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Partial Provisional Audit
Premises audited:	Kiri Te Kanawa Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	**Start date:** 27 March 2014 **End date:** 27 March 2014

Proposed changes to current services (if any):
The service is opening a new rest home wing of 12 beds on level two and a new secure dementia wing of 16 beds on level two.

Total beds occupied across all premises included in the audit on the first day of the audit:	57

Audit Team

Lead Auditor	XXXXX	**Hours on site**	4	**Hours off site**	2
Other Auditors		**Total hours on site**		**Total hours off site**	
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	4	Total audit hours off site	3	Total audit hours	7

Number of residents interviewed		Number of staff interviewed	1	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	75	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

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

Dated

Executive Summary of Audit

General Overview
Kiri Te Kanawa Retirement Village is a Ryman Healthcare facility, situated in Gisborne. The care centre (hospital, rest home and six-bed dementia unit) on level one was opened November 2011. There are currently 52 residents in the care centre (19 hospital, 30 rest home, and three dementia) and five rest home residents in the 30 serviced apartments certified for rest home level care. The care centre extends over two levels. This partial provisional audit included verifying the 16-bed dementia unit situated on level two and the additional 12-bed rest home care centre on level two. When the new dementia unit opens (level 2); the current six-bed dementia unit (level one) will have the secure door removed and these beds will revert to hospital level care. Ryman and Kiri Te Kanawa have been proactive in preparing for the special care unit and have developed quality objectives and strategy plans around the implementation of the unit. The organisation completes annual planning and has comprehensive policies/procedures to provide rest home, hospital/medical and dementia level care. This partial provisional audit identified that the environment, draft rosters and processes are appropriate for providing increased dementia level care and increasing rest home resident numbers and in meeting the needs of the residents. Improvements are required by the service are in relation weight loss management, pain monitoring and aspects of medication management.

Outcome 1.1: Consumer Rights

Outcome 1.2: Organisational Management
Ryman Healthcare has an organisational total quality management plan and key operations quality initiatives. Quality objectives and quality initiatives are set annually. There are annual Ryman objectives and special quality projects. To monitor organisation performance, the manager reports weekly to head office and Quality Monitoring Programme (RAP) committee meetings are monthly. The service has policies, 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, standards compliance and the quality of service delivery in the facility and across the organisation and there are clear guidelines and templates for reporting. A quality improvement plan has been implemented for Kiri Te Kanawa annual objectives and progress is monitored through the monthly RAP committee. The '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 and rosters are in place and are adjustable depending on resident numbers. The units will be managed by a registered nurse who will be supervised by the clinical manager responsible for the care and services of the residential complex. The unit RN will also be supported via collegial relationships with the registered nurses working within the care centre wings on level one. All caregivers currently employed to work in the dementia unit have completed the required dementia standards and advised that all new caregivers will be supported to commence the required dementia standards following completion of foundations level two. The service is currently employing caregivers and registered nurses.

Outcome 1.3: Continuum of Service Delivery

Five files were reviewed around weight loss management and pain monitoring. Improvements continue to be required in these areas. The service has a large workable kitchen that contains a walk-in chillier. The menu is designed and reviewed by a registered dietitian at an organisational level. There is a four-week rolling menu. Residents have had a nutritional profile developed on admission. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur. Fridge/freezer temperatures and food temperatures are undertaken daily and documented. Food is to be transported by kitchen staff to the dementia unit in hot boxes and served to residents from the kitchenette in each of the unit. There are appropriate policies and processes implemented around medication management. There is a treatment room in each of the two new wings. Staff who administer medication have been assessed as competent to do so. Improvements are required around aspects of medication management.

Outcome 1.4: Safe and Appropriate Environment

The service has waste management policies and procedures for the safe disposal and management of waste and hazardous substances. Staff will be trained in waste management. The incident reporting process includes investigation of these types of incidents. There is appropriate protective equipment and clothing for staff.

The new units are purpose-built and the design modelled on previously opened Ryman facilities. All building and plant have been built to comply with legislation. The building certificate for public use has been obtained. The organisation has purchased all new equipment for the units. Residents are able to bring their own possessions into the home and are able to adorn their room as desired. There are handrails in en-suites and hallways on each floor. All rooms and communal areas allow for safe use of mobility equipment. The dementia unit includes the Austco security system. Resident rooms are of appropriate size to ensure safety is not compromised. There is a transportation of resident's policy, which provided guidelines for managing resident and staff safety.

In the dementia unit, a secure external courtyard is situated directly off the open plan lounge and dining area. This allows for easy indoor/outdoor floor and supervision. The outdoor area includes planter gardens, built in outdoor seating and a navigation gate. This area is fully secured with custom designed trellis constructed from heavy-duty timber, laminated safety glass and a 600mm overhang to ensure resident safety and security.

All bedrooms have en-suites and there are adequate number of toilets, which are easily accessible from communal areas. Fixtures, fittings and floor and wall surfaces in bathrooms and toilets are made of accepted materials for this environment. Hot water temperature monitoring is completed. Resident rooms are of sufficient space to ensure care and support to all residents and for the safe use of mobility aids. Transfer of residents between rooms/floors can be accommodated by ambulance stretcher if necessary.

The open-plan living areas, consisting of lounge and dining areas and hallways are spacious and allow maximum freedom of movement while promoting the safety of residents who are likely to wander and the use of mobility equipment.

The Ryman group has robust housekeeping and laundry policies and procedures in place. The facility has a secure area for the storage of cleaning and laundry chemicals. Laundry and cleaning processes are monitored for effectiveness.

The Ryman group emergency and disaster manual includes (but not limited to) dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. There is an approved NZFS fire evacuation scheme for the entire building (this has not required altering). As the second floor has not been opened, staff designated for this unit have not completed a fire drill or training around the fire evacuation procedure. The facility includes the Austco call bell system. The "Austco Monitoring programme" is available in each bedroom and ensuite to ensure the resident is effectively monitored with dignity and limited interruption. The system includes sensor bed mats that activate the lights in resident rooms, so when a resident gets up at night the light in their en-suite automatically turns on, this prompts the resident to go to the toilet and then on leaving the ensuite the light above the resident's

bed illuminates and encourages the resident to go back to bed. This system is controlled by a timer and therefore can be set to meet the needs of individual needs of each resident. The door to each bedroom is also reed switched and should the resident open their door at night (or after their sensor system has been set), the alarm activates on the staff members pager. This way the staff member is alerted to which residents are up and wandering. There is also nurse presence bell, when a nurse/carer is in the resident room a green light shows staff outside that a colleague is in a particular room. General living areas and resident rooms are appropriately heated and ventilated, all rooms have windows.

Outcome 2: Restraint Minimisation and Safe Practice

Outcome 3: Infection Prevention and Control

Infection control is integrated as part of the bi-monthly health and safety meeting with discussion also at the RAP, staff and management meetings. Monthly collation tables from the facility are forwarded to Ryman head office for analysis and benchmarking. The infection control officer implements the surveillance, organises training and implements and reviews internal audits with oversight from the clinical manager.
The infection control policies are comprehensive and reflect best practice.
Infection control training is provided to staff annually, as is hand-washing training.
All infections are documented monthly in an infection control register. A monthly infection control report is completed. A six monthly comparative summary is completed.
The infection control officer has access to the District Health Board, general practitioners, wound nurse specialist and other specialists as required.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	0	2	0	0
Criteria	0	34	0	0	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	65

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 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) The resident who has lost a substantial amount of weight in the rest home, and another in the hospital have no interventions related to this in the care plan, have not been seen by the GP in relation to weight loss and have not been referred to a dietitian. (ii) On-going pain monitoring is expected to be documented in progress notes. However, a review of medication administration records show that when the resident has pain (as determined by having pain relief administered) this is often not documented in the progress notes and there is little evidence of pain monitoring in progress notes.	(i)Ensure residents with weight loss have interventions relating to this in the care plan and are reviewed by the GP and a dietitian. (ii) Ensure there is on-going monitoring of pain for residents who experience pain.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		requirements and safe practice guidelines.				
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)Three of ten administration signing sheets in the rest home, dementia unit and hospital show that non-packaged regular medications are not always signed as administered. (ii) One rest home resident had a seven day course of chlorsig eye drops completed in January 2014. This has been signed as administered on nine occasions since 17 March 2014 despite not being prescribed. (iii) Three of the ten medication charts sampled do not always document an indication for use for PRN medications. (iv) D16.5.e.i.2; Seven of 10 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.	(i)Ensure medications are administered as prescribed. (ii) Ensure all medications administered have been prescribed. (iii) Ensure PRN medications include an indication for use. (iv) Ensure all medication charts are reviewed by the GP three monthly.	60

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Ryman Kiri Te Kanawa is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital level care for up to 99 residents, including rest home level care in 30 certified serviced apartments. Occupancy is 30 rest home residents and 19 hospital residents. There are three residents in secure dementia unit and five rest home residents in the serviced apartments.
This partial provisional audit included assessing the 16-bed dementia unit situated on level two and the additional 12-bed rest home care centre on level one. When the new dementia unit opens the current six-bed dementia unit will have the secure door removed and these beds will revert to 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. The service has in place an experienced village manager who has been at the service since it opened in November 2011 and who is supported by an experienced clinical manager.

ARC E2.1, The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.
ARC, D17.3di (rest home), D17.4b (hospital), The facility manager and clinical manager has maintained at least eight hours annually of professional development activities related to management. The facility manager has been in the role for the since November 2011 and has previous aged care management experience within Ryman. She is supported by an experienced clinical manager (who has been in role since May 2012) and Ryman regional manager.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: D19.1a; A review of the documentation, policies and procedures and from discussion with staff identifies that the service operational management strategies, quality and risk management programme which includes culturally appropriate care, is to minimize risk of unwanted events and enhance quality of service delivery for residents and other stakeholders. In the temporary absence of the village manager, the assistant manager fulfils the operational duties with support from the clinical manager. The assistant manager has been with Ryman facilities in administrative roles for over five years and is taking a leadership role at Kiri Te Kanawa in quality including health and safety. She is able to describe the role of providing leadership in the absence of the village manager with the support of the regional and systems managers. If the village manager is absent, operational management is also overseen by the assistant manager and the regional manager (confirmed by the village manager interviewed).

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

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

Attainment and Risk: 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: A register of registered nurse practising certificates is maintained within the facility. The current general practitioners' registrations are printed from the professional body's website. Kiri Te Kanawa is in the process of securing a contract with a GP to provide services. Currently residents retain their own GP's. 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. Five staff files were reviewed. All had completed reference checks, orientation and up to date appraisals. Kiri Te Kanawa has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as (but not limited to) caregiver, senior caregiver, registered nurse, H&S rep, clinical manager and gardener. The orientation/induction training for caregivers, on completion, is equivalent to foundations level two. There is a specific employees' induction manual. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent. The orientation process includes; full induction with all employees and caregiver modules followed by enrolment into the ACE programme to achieve ACE core, ACE advanced and/or ACE dementia, as appropriate, if not achieved prior to employment. The 2014 in-service programme is being implemented. A review of staff training records identified average attendance and staff complete staff comprehension surveys at least two annually. Registered nurses are supported to maintain their professional competency and there is a foreign-trained nurse development programme. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. The journal club has completed training (YTD) around UTI's, advance care planning, informed consent, code of rights and palliative care. Yearly formal performance review specific to RNs for reflective practice and setting goals including up skilling or other training or qualification goals. E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies. E4.5f: There are eight caregivers in the existing dementia unit; all have completed the required dementia standards. Advised that all new caregivers employed to work in the dementia unit will be supported to complete the required dementia standards.

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 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 Monday to Friday and there will be a registered nurse who works 40 hours per week across the new dementia and rest home units (the two units adjoin and the nurses' station has access from each). In the dementia unit (from opening until there are eight residents), there is one caregiver rostered each shift with support by the rest home/hospital as required. This will increased to two caregivers on a morning and afternoon shift once numbers are above eight. Caregivers in the dementia unit also provide activities to their residents with support by the activity team until there are eight residents after which time an activities coordinator will also be employed. The rest home will have two caregivers on morning shift and one of evening shift with a senior caregiver floating between the new rest home unit and the dementia unit on night shift. There is support by the existing rest home/hospital as required.

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 1.3.6: 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: The previous audit identified issues around weight loss management and pain assessments. A review of five files (one from the dementia unit, two from the rest home and two from the hospital) show that weight loss is well managed in the dementia unit including clear interventions in the care plan, provision of supplements and a high calorie diet and GP and dietitian input. However the resident who has lost a substantial amount of weight in the rest home, and another in the hospital have no interventions related to this in the care plan, have not been seen by the GP in relation to weight loss and have not been referred to a dietitian. Improvement continues to be required. All five files have a pain assessment. On-going pain monitoring is expected to be documented in progress notes. However, a review of medication administration records show that when the resident has pain (as determined by having pain relief administered) this is often not documented in the progress notes and there is little evidence of pain monitoring in progress notes. Improvement continues to be required.

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: The previous audit identified issues around weight loss management and pain assessments. A review of five files (one from the dementia unit, two from the rest home and two from the hospital show that weight loss is well managed in the dementia unit including clear interventions in the care plan, provision of supplements and a high calorie diet and GP and dietitian input. All five files have a pain assessment. On-going pain monitoring is expected to be documented in progress notes.
Finding: (i) The resident who has lost a substantial amount of weight in the rest home, and another in the hospital have no interventions related to this in the care plan, have not been seen by the GP in relation to weight loss and have not been referred to a dietitian. (ii) On-going pain monitoring is expected to be documented in progress notes. However, a review of medication administration records show that when the resident has pain (as determined by having pain relief administered) this is often not documented in the progress notes and there is little evidence of pain monitoring in progress notes.
Corrective Action: (i)Ensure residents with weight loss have interventions relating to this in the care plan and are reviewed by the GP and a dietitian. (ii) Ensure there is on-going monitoring of pain for residents who experience pain.
Timeframe (days): 90 *(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. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Any discrepancies are fed back to the pharmacy. The medication trolleys are kept in a locked treatment room in the rest home/hospital and dementia care unit. There is a treatment room and medication trolley for the new units. Registered nurses (RN's) in the hospital and senior caregivers in the rest home and dementia care unit are competency assessed annually. Medication education is attended annually. Controlled drugs are stored in the hospital-controlled drugs safe. Verbal orders are used as required. There are no self-medicating residents. Three of ten administration signing sheets in the rest home, dementia unit and hospital show that non-packaged regular medications are not always signed as administered. One rest home resident had a seven day course of chlorsig eye drops completed in January 2014. This has been signed as administered on nine occasions since 17 March 2014 despite not being prescribed. These are areas requiring improvement. PRN medications administered have a time of administration recorded. However, three of the ten medication charts sampled do not always document an

indication for use for PRN medications. Controlled drugs are signed as given by two medication competent staff. Controlled drugs stock is checked weekly. There is also a pharmacy audit six monthly. Medication fridge temperatures are monitored weekly. There is a medication fridge in the new treatment room. 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. Ten of 10 medication charts sampled have photos and allergies/adverse reaction documented.
D16.5.e.i.2; Seven of 10 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. This is a further area requiring improvement.

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. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Any discrepancies are fed back to the pharmacy. The medication trolleys are kept in a locked treatment room in the rest home/hospital and dementia care unit. There is a treatment room and medication trolley for the new units. RN's in the hospital and senior caregivers in the rest home and dementia care unit are competency assessed annually. Medication education is attended annually. Controlled drugs are stored in the hospital controlled drugs safe. Verbal orders are used as required. PRN medications administered have a time of administration recorded. Controlled drugs are signed as given by two medication competent staff. Controlled drugs stock is checked weekly. There is also a pharmacy audit six monthly. Medication fridge temperatures are monitored weekly. There is a medication fridge in the new treatment room. 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. Ten of 10 medication charts sampled have photos and allergies/adverse reaction documented.

Finding:

(i)Three of ten administration signing sheets in the rest home, dementia unit and hospital show that non-packaged regular medications are not always signed as administered. (ii) One rest home resident had a seven day course of chlorsig eye drops completed in January 2014. This have been signed as administered on nine occasions since 17 March 2014 despite not being prescribed. (iii) Three of the ten medication charts sampled do not always document an indication for use for PRN medications. (iv) D16.5.e.i.2; Seven of 10 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Corrective Action:

(i)Ensure medications are administered as prescribed. (ii) Ensure all medications administered have been prescribed. (iii) Ensure PRN medications include an indication for use. (iv) Ensure all medication charts are reviewed by the GP three monthly.

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 currently two chefs and a kitchen hand in the large commercial kitchen in the service area of the group floor. The service has a large workable kitchen that was designed for the increase in resident numbers. The menu is designed and reviewed by a registered dietitian at an organisational level, which is reviewed by the chef at Kiri Te Kanawa weekly. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific cultural requests if needed. Kitchen fridge, food and freezer temperatures are monitored and documented daily. Food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene and infection control and special diets, Residents likes, dislikes and allergies are relayed to the kitchen. Food is to be transported by kitchen staff to the dementia wing and new rest home wing in bain maries and served to residents from the bain marie's in the servery/kitchenette in each of the units. There is a lift to allow for easy access from the kitchen. The kitchen in the special care unit is open plan and the hot water is behind a locked cupboard. There is also other lockable cupboards. Food temperatures are conducted before food is sent out of the main kitchen. The spacious dining areas and open plan lounge/dining area allows residents to wander with a sense of homeliness with the open kitchenettes. The server will also hold “food on the run” items for residents requiring high calorie intake or who tend to eat/graze continually. All residents admitted have a nutritional profile, which is provided to the kitchen. This is to be reviewed six monthly as part of the care plan review or as needs change. The chef described how changes to residents’ dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the kitchen notice board.

The new dementia unit and rest home unit each have an open plan kitchenette that residents and staff can access.
E3.4f There is a fridge in each of the units for extra food to be stored. The dining area is large enough to allow for use of mobility equipment and the movement of residents.
Ryman has an organisational process whereby all residents have a nutritional profile completed on admission, which is provided to the kitchen. There is access to a community dietitian.
Regular audits of the kitchen fridge/freezer temperatures and food temperatures are undertaken and documented as part of the RAP programme. Kitchen hygiene & food storage audit and servery kitchen & food storage audit. Food in the pantry is kept off the ground. Food in the fridge and chillers is covered and dated. Food safety in-service training is conducted. These processes are well established throughout Ryman services.

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

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk:	FA
Evidence:	
There are documented processes for waste management. This includes waste management - general waste policy, waste management - medical waste policy and waste management - sharps policy. The policies document procedures for the safe and appropriate storage, management, use and control and disposal of waste and hazardous substances. There is a locked cleaner's room/cupboard and sluice in the dementia unit and a locked sluice in the new rest home. Gloves, aprons, and goggles have been purchased and to be installed in the sluice and cleaners cupboards on floor two. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Training on the use of personal protective equipment (PPE) is included in the all employees induction programme.	

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

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

Attainment and Risk: 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 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

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

Attainment and Risk: 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 1.4.2: 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 facility is purpose-built and the design modelled on previously opened Ryman facilities, including level two, which includes the new dementia unit and rest home unit. All building and plant have been built to comply with legislation. The organisation has purchased all new equipment for both units.
The large atrium is landscaped and includes a water feature, gardens, and seating.

Rest home (level two).
The new rest home unit is designed with a service area consisting of a centrally located nurse station (this opens on to both the rest home and the dementia unit) that has access to a treatment room and clinical coordinators office. These service areas are situated adjacent to the spacious open plan dining and open plan lounge area. This ensures that staff are in close contact with residents even when attending to paper work or meetings. There is also a clinical manager's office.
There are handrails in en-suites and hallways. All rooms and communal areas allow for safe use of mobility equipment.
The rest home has carpet tiles with vinyl/tiled surfaces in bathrooms/toilets and kitchen areas. There is adequate space in the new unit for storage of mobility equipment.
There are a number of landing strips purchased and sensor mats.

Dementia unit.

This centrally located nurse station (which also opens onto the rest home unit) is directly off the open plan aspect of the dining and lounge area, ensures that staff are in close contact with residents even when attending to paper work or meetings.
The care centre building Certificate of Public Use (CPU) includes the level two dementia unit and rest home unit, which were built at the time of the original building. The CPU expires on 9 September 2014.
The units have been specifically designed and purpose-built by Ryman's in-house development team. This team also keeps track of international research to ensure appropriate and effective design and flow of these specialised units. In addition, the designs are a reflection of resident, relative and staff feedback from other Ryman dementia units.
The dementia unit connects via a secure entrance to the main care centre building. There is a foyer before entering through a secure door into the dementia units (a door for each unit).
There are handrails in en-suites and hallways. All rooms and communal areas allow for safe use of mobility equipment.
The dementia unit also includes the Austco security system, which includes sensor lights in resident rooms, so when a resident gets up at night the lights illuminate depending on the location of the resident within the room This is connected to the security system and can be timed to alarm if the resident does not go back to their bed.
E3.4a; The centrally located nurse station directly off the open plan aspect of the dining and lounge area, ensures that staff can supervise residents when doing paper-work. The roster has been designed to ensure supervision of the lounge and the closed circuit monitoring system assists with supervising residents in the long hallways.
The units design and equipment purchased specifically consider residents with confused state. The lighting is 2x the normal lighting due to research from dementia experts. Lighting is a mixture of ceiling and wall lights, which effectively assists in the contrast between night and day. There is also plenty of natural light with large windows. There are way finding decals in place. To encourage residents to find their way around the unit and turn at the end of corridors there is to be extensive use of "cues" such as decals, framed prints, textural and ornamental wall fixtures and various wall paint colours. The use of decals down corridors is a useful prompt for residents when returning to their bedroom. Doors are different colours to walls. The wall behind the toilet is darker to assist with making the toilet more noticeable. Like other Ryman dementia units the use of painted walls and decals and photos describing a story are useful ways to de-escalate behaviour and encourage residents to

reminisce.
The new unit has carpet tiles with vinyl/tiled surfaces in bathrooms/toilets and kitchen areas. There is adequate space in the new units for storage of mobility equipment. The units are designed with a service area consisting of a centrally located open-nurse station that is accessed from both wings separately. Access to a treatment room and clinical coordinators office is off the lounge. This centrally located nurse station directly off the open plan aspect of the dining and lounge area ensures that staff are in close contact with residents even when attending to paper work or meetings. The dementia unit has an open plan dining and lounge area. This design layout enhances the resident's freedom of movement, and ensures staff are able to supervise and monitor residents as they go about their day in a non-intrusive manner.
The dementia unit has a secure external courtyard that is situated directly off the open plan lounge and dining areas in each wing. This allows for easy indoor/outdoor flow and supervision.
This area includes planter garden boxes and built-in outdoor seating that are to be strong, sturdy and secure and at a reasonable height to assist residents' use and mobility. All flooring surfaces on the outdoor courtyard are maintained in a safe, non-slip and obstacle free manner to encourage enjoyment of the outdoor area. The area has artificial grass.
The trellis is custom made in a heavy weight timber, which is screwed together and designed to resist horizontal forces that comply with the NZ Building Code. There is a 600mm overhang off the trellis so residents are unable to climb over this trellis. [Advised that the windows fixed within the trellis are constructed from Safelight PVB, which is a laminated safety glass with a Polyvinyl Butyral (PVB) layer. Laminated glass offers greater protection for people by providing an effective barrier. The glass will break under sustained and strong/heavy smashing forces; however, the interlayer resists penetration, ensuring any attempt to exit a premise will be slow and noisy. When subjected to human or other impact the bond between the glass and interlayer adheres any broken fragments, keeping the glass intact and resisting penetration].
This outdoor area links directly off the lounge and dining room areas. This area is of adequate size and the design is used successfully in other Ryman villages.

There is a central courtyard the care centre surrounds (level one and two). The large atrium is overlooked by the new dementia and rest home units and includes seating and gardens. Landscaping and patching is in the process of being completed externally.

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: All residents rooms have a private en-suite which have access to a hand basin and paper towels. There are also well placed communal toilets off the communal areas in the rest home and the dementia units. There are adequate numbers of toilets and showers with access to a hand basin and paper towels.

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

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

Attainment and Risk: 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 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

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

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

Attainment and Risk: FA
Evidence: Residents rooms in the both units are single and of a generous size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)
Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)
Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: In the dementia unit: The unit has an open-plan living area. The living area is spacious with an open plan dining area. E3.4b; The open-plan living area, hallways are spacious and allow maximum freedom of movement while promoting the safety of residents who are likely to wander. The rest home unit also has a large open plan dining and living area sufficient for 12 residents.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)
Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: 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 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

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

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

Attainment and Risk: FA
Evidence: The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. There is an employed laundry person daily. The laundry is in the service area and has an entrance for dirty laundry and an exit for clean. The laundry is large and has commercial washing machines and dryers. The Ecolab manual includes instructions for cleaning. Linen is transported to the laundry in covered linen trolleys. The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme. Linen services - laundry hygiene audit. Housekeeping hygiene audit. These are being implimented. The service has a secure area for the storage of cleaning and laundry chemicals. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are available and displayed in the cleaning cupboards, laundry and sluices. The laundry and cleaning areas have hand-washing facilities.

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

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

Attainment and Risk: 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 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

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

Attainment and Risk:	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 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

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

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

Attainment and Risk:	FA

Evidence:

The Ryman group emergency and disaster manual includes (but not limited to) dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Emergencies, first aid and CPR is included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Orientation includes emergency preparedness. Fire drills are scheduled for staff during induction and six monthly. As the dementia unit and rest home unit has not yet opened, staff have not completed a fire drill or training around the fire evacuation procedure. However most staff are transferring from within the servcie so have completed this training.
As per Ryman policy, staff are required to complete emergency response training every two years. Internal training is entirely specific to the provision of service and is specific to the response considered appropriate to older person's health needs within a defined environment. Emergency procedures are included in orientation. All registered nurses have current first aid certificates.
D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.
The fire evacuation plan is unchanged from the original approved plan as there has been no addition to the building. The NZ Fire Service approved the scheme on 16 April 2012. Smoke alarms, sprinkler system and exit signs in place.
The service has alternative cooking facilities (gas cooker) available in the event of a power failure. Battery operated emergency lighting is in place for two hours. There are also extra blankets available. There is a civil defence kit for the whole facility and stored water. There is a Civil defence folder that

includes procedures specific to the facility and organisation.
Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. Senior caregivers carry a pager and all calls are signalled on a screen with the room number at varied places throughout the facility.
Due to the large size of resident rooms, a wireless call bell system has been installed so that call bells are in reach of residents sitting in armchairs in their rooms.
In the dementia units the "Austco Monitoring programme" is available in each bedroom and ensuite to ensure the resident is effectively monitored with dignity and limited interruption. The system includes sensor lights in resident rooms which illuminate depending on the location of the resident in the room. This is controlled by a timer, so can be set to meet the needs of individual residents. There is also nurse presence bell, when a nurse/carer is in the resident room a green light shows staff outside.
The rest home also includes the Austco call bell system. When residents ring a light shines outside there room, on a control panel and also goes to staff pages. There is also a certain call sound. When a staff member is in a resident room a green light shines above the resident's door. This allows for staff to know where other staff are. If the staff member with a resident rings the bell for another staff member assist, this ring is different and allows for staff to alert other staff for assistance without leaving the resident unattended.

There is an entrance and reception area on entering the units via a lift/stairs. The entire facility is secured at night. The service utilises security cameras and an intercom system. The Ryman group has an adequate security checks policy and procedure.
Advised that a closed Circuit Monitoring System with a 4 or 6 screen split that is to be located on the nurse station desk. This system monitors the corridors of each wing and staff then are able to unobtrusively monitor residents who may be mobilising in corridors.

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

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

Attainment and Risk: 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 1.4.7.3 (HDS(C)S.2008:1.4.7.3)
Where required by legislation there is an approved evacuation 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.)*

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)
Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: 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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when 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 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

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

Attainment and Risk: 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 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: General living areas and resident rooms are appropriately heated and ventilated. There are heat pumps in the ceiling of the lounges and in-built scope heaters in resident rooms. All rooms have external windows.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)
Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: 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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)
All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There are policies including a) a scope and application of the NZ standard for IC policy, b) infection control management policy, c) infection control governance policy, and d) defined and documented IC programme policy. There are clear lines of accountability to report to the infection control (IC), team on any infection control issues including a reporting and notification to head office policy. An infection control responsibility policy includes chain of responsibility and an infection control officer job description. The defined and documented IC programme policy states that the infection control programme is set out annually from head office and is directed via the Ryman Accreditation Programmes annual calendar. The annual review policy states IC is an agenda item on the two monthly head office health and safety committee. Kiri Te Kanawa also undertakes a six monthly comparative summary report on all infections that is reported to staff (last completed in March 2013). The service infection control manual includes a policy on a) admission of resident with potential or actual infections policy, b) infectious hazards to staff policy, c) outbreak management d) staff health policy and e) isolation policy.

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

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

Attainment and Risk: 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 3.1.3 (HDS(IPC)S.2008:3.1.3)

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

Attainment and Risk: 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 3.1.9 (HDS(IPC)S.2008:3.1.9)

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

Attainment and Risk: 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: Not Audited
Evidence:

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