# Charles Fleming Retirement Village Limited

## Current Status: 10 June 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Certification 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

Charles Fleming Retirement Village is a Ryman Healthcare facility, situated in Waikanae. The Charles Fleming facility is modern, spacious and extends across three levels. The facility provides rest home, hospital and dementia level care. On the day of audit there were 37 (of 40) rest home residents on level one (ground level), 26 (of 40) hospital residents on level two and 14 (of 40) residents in the special care unit (dementia) on level three.

The 23 serviced apartments have been assessed as suitable to provide rest home level care and there is currently one rest home resident in an apartment. The village manager is suitably qualifed and is supported by a clinical manager (registered nurse) who oversees the care centre. There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There are improvements required around incident reporting, staffing, documentation, aspects of medication management and care planning.

## Audit Summary as at 10 June 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 10 June 2014

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

### Organisational Management as at 10 June 2014

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

### Continuum of Service Delivery as at 10 June 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 10 June 2014

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

### Restraint Minimisation and Safe Practice as at 10 June 2014

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

### Infection Prevention and Control as at 10 June 2014

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

## Audit Results as at 10 June 2014

### Consumer Rights

Charles Fleming endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are being implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are being implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaint processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### Organisational Management

Charles Fleming is beginning to implement the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Charles Fleming provides clinical indicator data for the three services being provided (hospital, rest home and dementia). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. There are three improvements required around incident reporting, documentation and staffing.

### Continuum of Service Delivery

Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe, monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six monthly. The resident/family/whanau interviewed confirm they are involved in the care plan process and review. Short term care plans are in use for changes in health status. There is an improvement required around the documentation of interventions to reflect the resident’s current needs. The activity officer provides an activities programme in each unit that meets the abilities and recreational needs of the residents that is varied, interesting and involves the families and community. There are 24 hour activity plans for residents in the dementia care unit that is individualised for their needs. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. There is an improvement required around medication documentation. Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

### Safe and Appropriate Environment

The building is currently operating under a certificate of public use dated 25 July 2013. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have en-suites. There is sufficient space to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There are six monthly fire drills. Staff have attended emergency and disaster management, there is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

### Restraint Minimisation and Safe Practice

There are comprehensive policies and procedures that meet the restraint standards. There is a restraints officer with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at registered nurse, staff and management meetings. There is restraint education at orientation and on-going. There are three residents with restraints in use and two residents with enablers in use.

### Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive on-going training in infection control.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **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:** | Charles Fleming Retirement Village Limited |
| **Certificate name:** | Charles Fleming Retirement Village Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Certification Audit | | | |
| **Premises audited:** | Charles Fleming 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:** | 10 June 2014 | **End date:** | 11 June 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 77 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 16.5 | **Hours off site** | 8 |
| **Other Auditors** | XXXXX | **Total hours on site** | 16.5 | **Total hours off site** | 7 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 33 | Total audit hours off site | 18 | Total audit hours | 51 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 10 | Number of staff interviewed | 21 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 18 | Total number of staff (headcount) | 96 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of 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 | Not Applicable |
| 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 Wednesday, 16 July 2014

## **Executive Summary of Audit**

**General Overview**

Charles Fleming Retirement Village is a Ryman Healthcare facility, situated in Waikanae. The Charles Fleming facility is modern, spacious and extends across three levels. The facility provides rest home, hospital and dementia level care. On the day of audit there were 37 (of 40) rest home residents on level one (ground level), 26 (of 40) hospital residents on level two and 14 (of 40) residents in the special care unit (dementia) on level three. The 23 serviced apartments have been assessed as suitable to provide rest home level care and there is currently one rest home resident in an apartment. The village manager is suitably qualifed and is supported by a clinical manager (registered nurse) who oversees the care centre. There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. There are improvements required around incident reporting, staffing, documentation, aspects of medication management and care planning.

**Outcome 1.1: Consumer Rights**

Charles Fleming endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are being implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are being implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaint processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

**Outcome 1.2: Organisational Management**

Charles Fleming is beginning to implement the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Charles Fleming provides clinical indicator data for the three services being provided (hospital, rest home and dementia). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. There are three improvements required around incident reporting, documentation and staffing.

**Outcome 1.3: Continuum of Service Delivery**

Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe, monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six monthly. The resident/family/whanau interviewed confirm they are involved in the care plan process and review. Short term care plans are in use for changes in health status. There is an improvement required around the documentation of interventions to reflect the resident’s current needs. The activity officers provides an activities programme in each unit that meets the abilities and recreational needs of the residents that is varied, interesting and involves the families and community. There are 24 hour activity plans for residents in the dementia care unit that is individualised for their needs. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. There is an improvement required around medication documentation. Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

**Outcome 1.4: Safe and Appropriate Environment**

The building is currently operating under a certificate of public use dated 25 July 2013. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have en-suites. There is sufficient space to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There are six monthly fire drills. Staff have attended emergency and disaster management, there is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

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

There are comprehensive policies and procedures that meet the restraint standards. There is a restraints officer 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 on-going. There are three residents with restraints in use and two residents with enablers in use.

**Outcome 3: Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive on-going training in infection control.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 45 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 96 | 0 | 4 | 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 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Three resident files were traced (two hospital and one rest home) and there were incidents recorded in the progress notes that did not have an associated incident form examples include: a rest home resident fall, a hospital resident who was reported as ‘hitting out’ , and three incidents in one hospital file that included two unwitnessed falls and one episode of aggressive behaviour. As resident care plans and supporting documentation is evident (refer evidence 1.3.3) in files the risk is considered low. | Record resident incidents on the prescribed form. | 60 |
| HDS(C)S.2008 | Standard 1.2.8: Service Provider Availability | Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | During this audit the following was noted:  Staff interview confirms there are shifts that have not been able to be covered. In addition it was reported a number of ‘double shifts’ have been worked, this was verified during discussion with the assistant manager. It was estimated six double shifts per month have occurred.  Resident and relative interviews inform there are times when there are less staff available in the weekend. This is verified in resident/relative meeting minutes (March - hospital and May - special care unit 2014) where minutes record weekend staff are ‘stressed’ and there is ‘not enough staff’. Relative interview informed a call bell response time of approximately 20 minutes.  Weekly management meetings report a ‘number of permanent gaps’ in respect of staffing. | Continue to review staffing allocation in relation to resident needs. | 30 |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.9 | All records are legible and the name and designation of the service provider is identifiable. | PA Low | Entry in resident files are not consistently recording the time of entry, rather recording ‘am’, ‘pm’ and ‘nocte’. | Record the time of entry in resident files. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | (i)There are no pressure area interventions or management strategies documented in the care plan for a rest home resident. The same resident has wound discomfort identified in the pain assessment that is not reflected on the wound evaluation; (ii) There is no weight loss plan for one rest home resident with weight loss and wound. The notification to the kitchen does not document dietary requirements including high protein for weight loss and to aid wound healing; (iii) Associated risks with the use of the enablers (two hospital residents) are not documented in the care plan; (iv) There is no behaviour monitoring chart in place for a rest home resident with altered behaviours. | Ensure interventions are documented to reflect the resident’s current needs. | 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 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 | (i)There is no documented evidence of medications checked against the medication chart on delivery. (ii) There is transcribing on four non-packaged signing sheets (two special care unit and two rest home). | (i)Ensure medications are checked against the medication chart on delivery. (ii) Ensure there is no transcribing. | 60 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

Consumers receive services in accordance with consumer rights legislation.

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

**Attainment and Risk:** FA

**Evidence:**

Ryman policies and procedures are being implemented and align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interview with seven caregivers (two dementia, one serviced apartments/rest home and four who work across the hospital and rest home) demonstrate an understanding of the Code. Resident rights/advocacy training was provided April 2014 (18 attended). Residents interviewed (four rest home and six hospital) and relatives (three hospital, two rest home and one dementia care) confirm staff respect privacy, and support residents in making choice where able.

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

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

**Attainment and Risk:** 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 1.1.2: Consumer Rights During Service Delivery **(**HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

There is a welcome pack that includes information about the Code and the opportunity to discuss prior to, and during the admission process with the resident and family is provided. Information is also given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. Large print posters of the Code and advocacy information are displayed through the facility. The bimonthly resident meetings also provide the opportunity for residents and relatives to raise issues/concerns (minutes sighted). Residents interviewed (four rest home and six hospital) and relatives (three hospital, two rest home and one dementia) inform information has been provided around the Code. The village manager has an open door policy for concerns or complaints.  
D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability Commission. The village manager and clinical manager described discussing the information pack with residents/relatives on admission.   
D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

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

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

**Attainment and Risk:** 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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

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

**Attainment and Risk:** 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 1.1.3: Independence, Personal Privacy, Dignity, And Respect **(**HDS(C)S.2008:1.1.3)

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

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

**Attainment and Risk:** FA

**Evidence:**

Ryman has policies that support resident confidentiality, privacy, collection and storage of information, and access to health information (disclosure). A tour of Charles Fleming confirms there is the ability to support personal privacy for residents. During the audit, staff were observed to be respectful of residents’ privacy by knocking on doors prior to entering resident rooms. Resident files are stored out of sight. Staff could describe definitions around abuse and neglect that align with the Ryman policy. Six relatives interviewed stated that the care provided is overall good. Prevention and detection of abuse training was last delivered in May 2014 (36 staff attended). There is no evidence of abuse/neglect. An annual resident satisfaction survey has been completed. The results had yet to be aggregated for the facility, however the regional manager provided evidence that demonstrated survey feedback was generally ‘very positive’ about the way staff care for the resident, and comments were ‘generally good’ about the way staff communicate with residents.   
D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Interview with seven caregivers describe how choice is incorporated into resident cares. Interview with ten residents (four rest home and six hospital) inform staff are respectful. There is an abuse and neglect policy that is being implemented and staff attend in-service education on abuse and neglect. Interviews with residents and family members were generally positive about the care provided.  
E4.1a One relative (with a family member in the unit) interviewed stated their family member was welcomed into the dementia unit and personal items were evident in rooms to make it more familiar to the resident.   
D4.1a Nine resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with ten residents confirm their values and beliefs were considered.   
D14.4 There are instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.

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

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

**Attainment and Risk:** 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 1.1.3.2 (HDS(C)S.2008:1.1.3.2)**

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

**Attainment and Risk:** 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 1.1.3.6 (HDS(C)S.2008:1.1.3.6)**

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

**Attainment and Risk:** 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 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

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

**Attainment and Risk:** 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 1.1.4: Recognition Of Māori Values And Beliefs **(**HDS(C)S.2008:1.1.4)

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

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

**Attainment and Risk:** FA

**Evidence:**

A3.2 Ryman has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit the staff report there are two residents that identify as Maori and both are in the dementia unit. Neither resident was interviewed as part of the audit.  
D20.1i The Ryman Maori health policy guides staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.

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

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

**Attainment and Risk:** 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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

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

**Attainment and Risk:** 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 1.1.4.5 (HDS(C)S.2008:1.1.4.5)**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An initial care planning meeting is carried out, where the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with six relatives inform values and beliefs are considered. Discussion with ten residents (four rest home, six hospital) confirm that staff take into account their culture and values.  
D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.   
D4.1c Care plans reviewed included the residents’ social, spiritual, cultural and recreational needs.

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

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

**Attainment and Risk:** 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 1.1.7: Discrimination **(**HDS(C)S.2008:1.1.7)

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

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Ryman Accreditation Programme (RAP) full facility (include all staff) meetings occur monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager and seven registered nurses confirm an awareness of professional boundaries. Interview with seven caregivers (two dementia, one serviced apartments/rest home and four who work across the hospital and rest home) could discuss professional boundaries in respect of gifts.

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

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

**Attainment and Risk:** 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 1.1.8: Good Practice **(**HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

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

**Attainment and Risk:** FA

**Evidence:**

Ryman Healthcare has a Ryman Accreditation Programme (RAP) that includes an annual planning and a suite of policies/procedures to provide rest home care, hospital care and specialist dementia care. Policies are reviewed at an organisational level and input is invited from facility staff (verified via interview with registered nurse). All Ryman facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies.

Clinical indicator data is collected against each service level and reported through to head office for monitoring. Indicators include (but not limited to): falls, medication errors, infection. Feedback is provided to staff via the various meetings that are determined as part of the RAP. Quality Improvement Plans (QIP) are developed where thresholds exceed expectation – QIP for falls was sighted. QIP’s reviewed are seen to be resolved and closed out. Vcare is the electronic system used by all sites to report relevant information through to head office, and is seen to be used at Charles Fleming.

ARC A2.2 Services are provided at Charles Fleming that adhere to the health & disability services standards. There is a quality improvement programme that is being implemented that includes performance monitoring (link improvements identified 1.2.4). ARC D1.3 all approved service standards are adhered to.

There are human resources policies/procedures to guide practice, and an annual in-service education programme that is incorporated into the RAP. There is evidence at Charles Fleming that the in-service programme is being implemented. There is evidence of opportunistic education being provided via ‘toolbox’ sessions.

ARC D17.7c There is implemented competencies for caregivers and registered nurses. Core competency assessments and induction programmes are being implemented at Charles Fleming. Competencies are completed for key nursing skills including (but not limited to); a) moving & handling, b) insulin, c) sub cut fluids and d) medication. RNs have access to external training.

Discussions with residents (four rest home, six hospital) and relatives (two rest home, three hospital, one dementia) were positive about the care they receive.

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

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

**Attainment and Risk:** 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 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an incident reporting policy, and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed (four from each service level) identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters is available.   
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry  
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  
D16.4b Six relatives (three hospital, two rest home and one dementia) stated that they are informed when their family members health status changes.  
D11.3 The information pack is available in large print and this can be read to residents.

##### **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 1.1.10: Informed Consent **(**HDS(C)S.2008:1.1.10)

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

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

**Attainment and Risk:** FA

**Evidence:**

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Consent is obtained for release of health information, photograph for identification and promotional displays, care choice/procedures and release of information to family or representative. Seven caregivers interviewed (two dementia, one serviced apartments/rest home and four who work across the hospital and rest home) are familiar with the code of rights and informed consent when delivering resident cares.   
Resuscitation orders for competent residents are appropriately signed. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Advance directives are reviewed by the GP and residents are informed of their choice to withdraw or change their advance directive status. The GP discusses resuscitation with families/EPOA where the resident is deemed incompetent to make a decision. A medically indicated not for resuscitation decision may be made in consultation with the family/EPOA as evidenced on three files of nine residents deemed incompetent to make the decision.   
D3.1.d: Discussion with six family members identifies that the service actively involves them in decisions that affect their relative’s lives. Advanced directives are completed for residents who are competent to make the decision.   
D13.1: Nine admission agreements are sighted and signed.

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

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

**Attainment and Risk:** 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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

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

**Attainment and Risk:** 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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

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

**Attainment and Risk:** 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 1.1.11: Advocacy And Support **(**HDS(C)S.2008:1.1.11)

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

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

**Attainment and Risk:** FA

**Evidence:**

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the village manager, the assistant village manager and the clinical manager confirm practice is consistent with policy. Interviews with ten residents (six hospital and four rest home) confirm that they are aware of their right to access advocacy.  
D4.1d; Discussions with six family members confirm that the service provides opportunities for the family/EPOA to be involved in decisions   
ARC D4.1e. The resident files include information on residents’ family/whanau and chosen social networks.

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

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

**Attainment and Risk:** 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 1.1.12: Links With Family/Whānau And Other Community Resources **(**HDS(C)S.2008:1.1.12)

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

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

**Attainment and Risk:** FA

**Evidence:**

D3.1h: Interview with ten residents and six relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit.  
The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with ten residents confirm the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.  
D3.1.e Discussion with seven caregivers, three activities coordinators, six relatives and ten residents confirm that residents are supported and encouraged to remain involved in the community and external groups.

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

Consumers have access to visitors of their choice.

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

Consumers are supported to access services within the community when 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 1.1.13: 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 complaints policy and supporting documents that is being implemented. The village manager is overall responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A feedback form is completed for each complaint recorded on the complaint register/s. The number of complaints received each month is reported monthly to staff via the various meetings – eg. Caregivers, full facility, registered nurse (RN). There is a complaint register maintained for each service area and includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with ten residents and six relatives confirm they were provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility. The complaints were reviewed since Charles Fleming opened and included one recorded complaint in the rest home (dated January 2014) which is closed and two in the hospital (November 2013 and June 2014). The complainant of the June 2014 complaint was interviewed and reports actions being taken on the identified issue and follow-up by the village manager. This complaint is still in process at the time of audit.   
D13.3h. a complaints procedure is provided to residents within the information pack at entry.

##### **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:**

Charles Fleming provides care across three levels. On the day of audit there were 37 (of 40) rest home residents on level one (ground level), 26 (of 40) hospital level residents on level two, and 14 (of 40) dementia level residents in the special care unit on level three. There is also one rest home level resident in a serviced apartment in the care centre. Levels one, two and three are all the same layout with the upper levels being accessible by lift or stairs. The 40 dementia level beds are made up of two 20 bed units.

There is a documented ' purpose, values, scope, direction & goals policy. 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 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. Ryman Healthcare have operations team objectives 2014 that include a number of interventions/actions for; a) quality system focus forward, b) national dementia project, c) human resources - recruitment/induction processes, d) health and safety, e) InterRAI project, and f) clinical education. Each service also has their own specific RAP objectives. 2014 objectives for Charles Fleming include the establishment of specialised roles such as infection control officer, quality assistant, fire and health and safety officer; and implementation of staff induction processes.

The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and specialist dementia care. There is a medical component to the certificate. There is a contracted physiotherapist that provides services two days (8 hours) a week and a physiotherapist assistant that works 15 hours per week. There is a contracted medical centre that provides as required services.

The village manager at Charles Fleming was previously village manager at Rita Angus and has health care management experience in homecare. The village manager has completed specific manager orientation with Ryman and attends the annual Ryman manager's conference. She is supported by an assistant manager who carries out administrative functions and a clinical manager (RN) who oversees clinical care at the care centre. The clinical manager has worked in aged care for a number of years as a senior registered nurse and started at Charles Fleming In August (2013). The management team is supported by the Ryman management team including regional manager.

The management resource manual includes a number of documented responsibilities of the manager including a list of reporting requirements. There is a manager's job description that includes authority, accountability and responsibility including reporting requirements. The Ryman managers complete a Leadership and Management course (an initiative by Ryman) that includes a number of modules. Management development programme includes self-directed learning packages.

##### **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:**

Policy 2.7.1 Staff administration identifies manager availability including on call requirements. During a temporary absence, the assistant manager and clinical manager will cover the manager’s role. The assistant manager covers administrative functions and clinical manager clinical care. The regional manager provides oversight and support.   
D19.1a: a review of the documentation, policies and procedures and from discussion with staff, identified the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

##### **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 1.2.3: 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:**

Charles Fleming is implementing the Ryman RAP system. Quality and risk performance is reported across the various meetings including (but not limited to) RAP Committee, full facility, registered nurse and caregivers. Issues are also reported through the weekly management meetings and a weekly report is provided to the regional manager.

The service has policies and procedures and the RAP programme defines systems to provide an 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. All facilities have a master copy of all policies & procedures with associated clinical forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow implementation by staff. A number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence/knowledge and education packages which are based on their policies.

Policy and procedure review is coordinated by head office, with facility staff having the opportunity to provide feedback (staff interview). Facility staff are informed of changes/updates to policy at the various staff meetings.

Key components of the quality management system link to the RAP committee at Charles Fleming who meet monthly. Weekly reports by the village manager to the regional manager and quality indicator reports to that are sent to head office (Christchurch) provide a coordinated process between service level and organisation. There are monthly accident/incident reports completed by the clinical manager collected across the rest home, dementia unit and hospital services (link 1.2.4), and staff incidents/accidents. The service has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. The Charles Fleming combined health and safety and infection control committee meet monthly and include discussion of incidents/accidents and infections. Infection control is also included as part of benchmarking across the organisation.

Charles Fleming is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified – eg wound audit. Repeat audit is required if results exceed the Ryman threshold (92%). Issues and outcomes are reported to the appropriate committee e.g. RAP. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets – eg. Falls. Weekly reporting to the regional manager includes bed state, staffing and incidents/complaints that meet the reporting threshold in the Ryman risk matrix. QIP’s reviewed are seen to have been closed out once resolved.

D19.3: There is a comprehensive H&S and risk management programme in place. There are policies to guide practice. Charles Fleming has an H&S representative recently appointed to the role (interviewed) who has recently completed training.

D19.2g Fall prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist and sensor mats.

##### **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:** PA Low

**Evidence:**

D19.3c: The service collects incident and accident data. Twelve randomly selected incident forms were reviewed between May and June (2014) that included four from each of the three service levels (rest home, hospital, dementia). The forms reviewed were completed as prescribed and signed out. Three resident files were traced (two hospital and one rest home) and there were incidents recorded in the progress notes that did not have an associated incident form and this is a required improvement.   
D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were cited for incidents above the benchmark for example falls. Corrective action plans were completed and signed off.   
Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Incident forms are completed and review of 12 randomly selected incident forms were reviewed between May and June (2014) noted forms are completed as prescribed and signed out. Monthly data is aggregated and analysed and reported through the various meetings. QIP forms are seen to be developed, resolved and closed out where a variance is found – eg. Falls.

**Finding:**

Three resident files were traced (two hospital and one rest home) and there were incidents recorded in the progress notes that did not have an associated incident form examples include: a rest home resident fall in January, a hospital resident who was reported as ‘hitting out’ in April, and three incidents in one hospital file (between March and May) that included two unwitnessed falls and one episode of aggressive behaviour. As resident care plans and supporting documentation is evident (refer evidence 1.3.3) in files the risk is considered low.

**Corrective Action:**

Record resident incidents on the prescribed form.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation provides documented job descriptions for all positions which detail each position’s responsibilities, accountabilities and authorities. Relevant documentation is seen in ten staff files reviewed (clinical manager who is the restraint coordinator, two registered nurses – one being the infection control officer, three caregivers, two activities coordinators, chef and an enrolled nurse who is working as a caregiver). Additional role descriptions are in place for infection control coordinator, Liverpool care pathway coordinator, restraint coordinator, in-service educator, health and safety officer, fire officer and quality assistant. Policy: Health practitioners and competencies outlines the requirements for validating professional competencies. A register of practising certificates is maintained. Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios and rostering. Interview with the management team (regional manager, village manager, assistant manager and clinical manager) inform there has been a degree of attrition with the caregiver staff (link 1.2.8) and recruitment continues.

There is a 2014 training plan developed for Charles Fleming that is aligned with the RAP. Staff education and training includes the ACE programme for caregivers. Ryman ensures RNs are supported to maintain their professional competency. There is an RN journal club that is required to meet two monthly at all Ryman facilities and subjects covered include (but not limited to) warfarin, wound management, Liverpool care pathway that has commenced at Charles Fleming. Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There are a list of topics that must be completed at least two yearly and this is reported on. Ryman has a 'Duty Leadership' training initiative that all RNs, ENs and Senior Leaders complete. It includes four modules/assignments around resident rights, customer service, leading colleagues and key operations/situations.

The clinical structure in the facility includes a clinical manager, registered nurse coordinators in each service area (rest home, hospital, dementia) and a team of registered nurses and care staff. The serviced apartments (where there is currently one rest home level resident) have a coordinator (non-practising enrolled nurse).

E4.5f: Since the previous audit there has been a new RN coordinator appointed to the special care unit. She has approximately 25 years’ experience including clinical management roles in aged residential care and dementia care. There are currently seven of 13 caregivers employed to work in the dementia unit that have completed dementia standards, three who are in the process of and three to progress.

Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and qualification to all care staff and actively support the Health Ed Trust ACE Programmes and provide incentives to their staff to undertake both the general and dementia modules. Completion of induction programme and required ACE dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme.

##### **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:** PA Low

**Evidence:**

Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Interviews with seven caregivers inform the RN’s (including coordinators) are supportive and approachable. There are three activity coordinators. While the reviewed roster meet required staffing ratios, there were a number of factors observed during the audit that would suggest there are times the facility is under pressure to safely meet the care needs of the residents including: a small number of double shifts being worked by staff, resident/relative/management meeting minutes report staffing issues and interviews during the audit indicate staffing shortfalls. Based on the evidence during the audit staffing should be reviewed.

##### **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:** PA Low

**Evidence:**

Policy 2.7.1 Staff Administration policy also includes the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Interviews with seven caregivers inform the RN’s (including coordinators) are supportive and approachable. There are three activity coordinators. Interview with the management team inform there has been a turnover of caregiver staff and active recruitment is in process.

**Finding:**

During this audit the following was noted:

1. Staff interview confirms there are shifts that have not been able to be covered. In addition it was reported a number of ‘double shifts’ have been worked, this was verified during discussion with the assistant manager. It was estimated six double shifts per month have occurred.
2. Resident and relative interviews inform there are times when there is less staff available in the weekend. This is verified in resident/relative meeting minutes (March - hospital and May - special care unit 2014) where minutes record weekend staff are ‘stressed’ and there is ‘not enough staff’. Relative interview informed a call bell response time of approximately 20 minutes.
3. Weekly management meetings report a ‘number of permanent gaps’ in respect of staffing.

**Corrective Action:**

Continue to review staffing allocation in relation to resident needs.

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard in both areas. Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.   
D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Entry in resident files are not consistently recording the time of entry and this is an area of improvement.

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

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

**Attainment and Risk:** 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 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

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

**Attainment and Risk:** 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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

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

**Attainment and Risk:** PA Low

**Evidence:**

In three (of four) files reviewed – one rest home in the serviced apartment, and two reviewed while tracking incident reporting – the time of entry is inconsistently reported.

**Finding:**

Entry in resident files are not consistently recording the time of entry, rather recording ‘am’, ‘pm’ and ‘nocte’.

**Corrective Action:**

Record the time of entry in resident files.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

All records pertaining to individual consumer service delivery are integrated.

**Attainment and Risk:** 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 1.3.1: Entry To Services **(**HDS(C)S.2008:1.3.1)

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a well-developed assessment process and resident’s needs are assessed prior to entry. The service has a comprehensive admission policies including: a) Entry of Resident to Services policy. The information booklet answers a number of questions around admission and entry processes. The Village Manager screens potential clients for entry to services and requests confirmation of level of care to be received the day prior to admission. Consultation occurs with clinical personnel regarding placement and specific clinical needs. Information gathered at admission is retained in resident’s records.

Four rest home and six hospital residents and six relatives interviewed (two rest home, three hospital and one dementia care) confirmed they received information prior to admission and discussed the admission process and admission agreement with the facility manager.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.

2. Behaviour management.

3. Complaint policy.

D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract. Nine admission agreements sighted had been signed.

D14.1: Exclusions from the service are included in the admission agreement.

D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1: Two resident files reviewed included a needs assessment as requiring specialist dementia care.

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

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

**Attainment and Risk:** 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 1.3.2: Declining Referral/Entry To Services **(**HDS(C)S.2008:1.3.2)

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The right to appeal against assessment outcome policy states the manager at every stage will inform the resident/family of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry is referred back to the Needs Assessors or referring agency for appropriate placement and advice.

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

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

**Attainment and Risk:** 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 1.3.3: 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 registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs of admission. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy. The nursing care assessment, service delivery policy, care planning and interventions policy describes the responsibility around documentation. There is a continuum of service delivery policy that includes guidelines for a) nursing care assessment, b) planning care interventions, c) service delivery/interventions, and d) evaluation and care plan review. Timeframes are identified for assessment, initial care plan, long term care plan and evaluations. RN's (interviewed) know the timeframes for the development and reviews of care plans and files. Clinical staff have attended in service and refreshers on clinical care including (but not limited to) behaviour management, pain management, personal hygiene and grooming, palliative care, care planning and ageing process. Activity assessments and activities Spice of Life plans have been completed by the activity co-ordinators.

D16.2, 3, 4; An initial assessment and initial care plan is completed within the required timeframes in nine of nine files sampled (two dementia care, three hospital and four rest home). The long term care plan has been developed within three weeks in eight of nine files sampled. One hospital resident had not been at the service three weeks. Four of nine long term care plans have been evaluated six monthly. Four residents (two hospital and two rest home) have not been at the service long enough for a long term care plan review. One hospital resident has not been at the service long enough for a long term care plan to be developed.

A physiotherapist is contracted to the service twice a week (four hours each day) to undertake new resident physio assessments, follow up any referrals, oversees the trial of equipment and forwards instructions to the physio assistant to continue treatments as required. Education in safe manual handling is provided as per the training schedule. The physio assistant (interviewed) has a certificate in sports and fitness development and is employed for 15 hours a week (three hours day a week) and works alongside the physio and ensures exercises, assisted walking and assessments are followed up as per the physio instructions. Both work in the hospital area. Rest home residents are seen by referral. Reports are documented in the resident integrated file. There is good communication between the clinical staff and physio team with verbal handovers and the use of a communication book.

D16.5e; Medical assessments were documented in all nine files within 48 hours of admission. Three monthly medical reviews were documented in nine of nine files by the general practitioner. It was noted in the resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care. Medical care is contracted and provided by three GPs from a local health centre. There are three visits per week which include three monthly reviews, admissions and addressing any resident concerns. The GP service is available form 8am – 7pm with a GP on call up to 10pm at the medical centre that has a 5 bed overnight stay if required. Extended care paramedics are based in the community to attend urgent calls. The GP liaises closely with the geriatrician and mental health services for the older person as required.

Seven caregivers (two dementia, one serviced apartments/rest home and four who work across the hospital and rest home) interviewed could describe a verbal handover at the beginning of each shift that maintains a continuity of service delivery. There is a duty handover form which is completed for each shift that lists any residents requiring any special observations or needs. Progress notes are written on every shift.

Tracer methodology dementia care resident

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

Tracer methodology hospital level of care resident

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

Tracer methodology rest home resident

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

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

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

**Attainment and Risk:** FA

**Evidence:**

The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whanau support, activities preferences, food & nutrition information and mental function.

Risk assessment tools and monitoring forms are available and implemented to assess level of risk and required support for residents including (but not limited to); a) waterlow pressure area risk assessment, b) skin integrity, c) three day continence assessment, d) coombes falls risk, e) dietary profile/nutritional needs screening f) pain/Abbey scale assessment g) physiotherapy assessment. h) Behavioural assessment i) wound assessment and enabler/restraint assessment (as applicable). Assessments are reviewed six monthly or when there is a change to condition.

ARC E4.2: Two resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a: Challenging behaviours assessments are completed. Behaviour nursing care plans are in place.

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

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

**Attainment and Risk:** 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:**

An initial support plan is completed within 24 hours. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality. Registered nurses are scheduled to attend InterRAI training. Interview with five registered nurses and two clinical co-ordinators verified involvement of families in the care planning process. Resident/family/whanau involvement is evidenced by written acknowledgment of care plan involvement.

Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as speech language therapist, physiotherapist, podiatrist, dietitians and mental health services. Activity officers maintain activity assessment/activity plans and evaluations in residents file. There are specific physiotherapy progress notes and podiatry visits are documented.

E4.3: Two of two resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k: Short term care plans are in use for changes in health status. Examples sighted are as follows: weight loss, skin tear, chest infection and UTI.

D16.3f: Nine resident files reviewed (two dementia, three hospital and four rest home) identified that the resident/family are involved in the development/evaluation of care plans. Relatives interviewed (one dementia care, three hospital and two rest home) confirm they are involved in the care planning process.

##### **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.)*

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

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Residents interviewed (six hospital, four rest home) report their needs are being appropriately met. Relatives interviewed (three hospital, one dementia care and two rest home) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. This is evidenced in the progress notes with a “relative contact” stamp.

D18.3 and 4: Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessment and wound treatment and evaluation plans are in place for one lesion in the dementia care unit, six wounds in the rest home and three wounds in the hospital. Short term care plans are in use for five skin tears in the hospital and three skin tears in the rest home. Skin tears unresolved after seven days are transferred to a wound assessment document. A wound and skin tear register is maintained. All wounds and skin tears have been evaluated the required timeframe as documented. There is one sacral pressure area (hospital acquired) in the hospital. There is an improvement required around interventions and management of the pressure area. The clinical manager is the “wound champion” for the service offering advice and education for all staff on wound care management. There is also has access to external to wound specialist as required. Wound care management has been attended by 12 RNs in May 2014.

Continence products are available and resident files include a three day 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 five RN's and two unit co-ordinators interviewed. Continence management has been attended by 101 staff to date for 2013.

Weigh chair scales (calibrated) are used to weigh residents monthly or more frequently for the monitoring of weight loss/gain. Weight loss short term care plans include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/Dietitian notification. Nutritional needs screening tools are evidenced in use. There is an improvement required around documentation of weight loss.

Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an assessment form for at risk residents. Accident /incidents are investigated for cause and corrective actions including a physiotherapist review, the use of sensor mats, hip protectors, clutter free rooms and mobility aids available.

Residents identified with behavioural or challenging behaviour have a behavioural assessment completed and behaviour nursing care plan that identifies the behaviour, triggers and interventions including activities over a 24 hour period that can be best used to manage behaviours. Behaviour monitoring charts are in place for all special care unit residents to monitor behaviours and the effects of commencement or reduction of psychotropic medications. There is an improvement required around the use of behaviour monitoring for a resident in the rest home.

There are two residents with enablers in use. The enablers are identified in the long term care plans. Associated risks with the use of the enablers are not documented in the care plan.

##### **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:**

There is one sacral pressure area (hospital acquired) in the hospital. There is a wound assessment and treatment/evaluation plan in place and a pressure area risk assessment. The clinical manager is the “wound champion” for the service offering advice and education for all staff on wound care management. There is also access to external to wound specialist as required. Wound care management has been attended by 12 RNs in May 2014.

Weigh chair scales (calibrated) are used to weigh residents monthly or more frequently for the monitoring of weight loss/gain. Weight loss short term care plans include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/Dietitian notification. Nutritional needs screening tools are evidenced in use.

There are two residents (hospital level) with enablers in use. The enablers are identified in the long term care plans.

Residents identified with behavioural or challenging behaviour have a behavioural assessment completed and behaviour nursing care plan that identifies the behaviour, triggers and interventions including activities over a 24 hour period that can be best used to manage behaviours. Behaviour monitoring charts are in place for all special care unit residents to monitor behaviours and the effects of commencement or reduction of psychotropic medications. There is an improvement required around behaviour monitoring for a rest home resident.

**Finding:**

(i)There are no pressure area interventions or management strategies documented in the care plan for a rest home resident. Wound discomfort identified in the pain assessment that is not reflected on the wound evaluation; (ii) There is no weight loss plan for one rest home resident. The notification to the kitchen does not document dietary requirements including high protein for weight loss and to aid wound healing; (iii) Associated risks with the use of the enablers (two hospital residents) are not documented in the care plan; (iv) There is no behaviour monitoring chart in place for a rest home resident with altered behaviours.

**Corrective Action:**

Ensure interventions are documented to reflect the resident’s 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 four activity coordinators (two in training) that provide a separate activity programme for the rest home, hospital and special care unit. As of the 23 June 2014 there will be a seven day programme in place. There are set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group. The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences', next of kin input into care and an activities plan. The plan includes categories for comfort and wellbeing, outings, interests and family and community links. There is a comprehensive programme that meets the needs of all consumers including but not limited to; news, reminiscing, triple an exercises, lounge games, carpet bowls, arts and crafts, board games, weekly movies in the cinema, cooking club, gardening club, happy hours and weekly sing-a-longs and entertainers. Rest home and hospital residents mix and mingle as desired. One on one time is spent with residents who choose not to participate or who choose not to join in group activities.

Residents are encouraged to maintain links with the community and there is contact with groups such as the blind foundation, stroke foundation, Alzheimer’s group, library, Kapiti college, SPCA (pet therapy), music and dance society. Church services are held weekly. There are regular outings and scenic drives for residents in all units. The service has two vans. A mobility taxi is hired to ensure hospital level residents (wheelchair bound) have an opportunity to go out. Festive occasions, special events and resident birthdays are celebrated. Residents in the dementia care unit are taken for supervised outdoor walks and scenic drives. Activities in the dementia unit are individualised and based on sensory activities and normal daily activities. The programme is reviewed weekly with Triple A attendance sheets being forwarded to head office. The activity team described the implementation of the 'Spice of Life', a resident focused programme to enable the village to support residents achieve self-setting goals. Resident meetings and surveys provide feedback on the activities programme. All 10 residents and six family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d. Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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 (sited in resident files). Short term care plans are utilised in the rest home, hospital, and dementia unit. Short term care plans are evaluated regularly and resolved or added to the long term care plan if an on-going problem. Any changes to the long term care plan are dated and signed. Family are invited to attend the multidisciplinary review meetings (correspondence noted in files reviewed). Resident medications and medical status are reviewed at least three monthly by the general practitioners.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated by the service. The clinical manager, two unit co-ordinators and five RN's interviewed state they initiate referrals to nurse specialist services. When the referral is to be made to a specialist a letter from the GP is then required, as confirmed by GP interview. Referrals and options for care are discussed with the family. Referrals sighted on the resident files sampled are as follows: physiotherapy, needs assessor, dietitian, geriatrician and mental health services for the older person.

D 20.1: discussions with registered nurses identified that the service has access to dietitian, physiotherapy, speech language therapist, wound care specialist, podiatrist and mental health nurses and practitioners, hospice nurses and specialists

D16.4c; the service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care such as respite care to rest home level of care.

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

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

**Attainment and Risk:** 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 1.3.10: Transition, Exit, Discharge, Or Transfer **(**HDS(C)S.2008:1.3.10)

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Transfer information is completed by the registered nurse or clinical manager and communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. The transfer of residents or admission to other provider’s policy includes instructions for documentation and whom to notify. One rest home file reviewed of a resident transferred acutely to hospital identified that a transfer form was completed and family notified. Relatives (three hospital, two rest home and one dementia) interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.

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

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

**Attainment and Risk:** 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 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. The service uses individualised medication blister packs for regular, “odd time” medications and PRN medications. There is an improvement required around the checking of medications against the medication chart on delivery. Three medication rooms are viewed (rest home, hospital and special care unit) and one medication cupboard (serviced apartments). All medications rooms are secure. Medications trolleys are locked. Contents are all within expiry dates and eye drops are dated on opening. Expiry dates of all medications are checked monthly. There is a specimen signature list of all medication competent persons. Caregivers administer medications in the serviced apartments, rest home and special care unit. RNs only administer medication in the hospital unit. Staff attended medication administration training in May 2014 and 21 staff completed medication and insulin competencies February 2014. RNs have complete syringe driver training. There are no self-medicating residents. There are current standing orders. Medication administration is observed to be compliant as sighted in the hospital dining room on day one and in the rest home on day two.

Controlled drugs safes are located in the medication rooms for each unit. There are weekly controlled drugs checks sighted in the controlled drug registers. The pharmacy undertake a six monthly controlled drug stocktake last completed December 2013. The RNs complete a stocktake at the bottom of each page in the controlled drug register. Medications to be returned to the pharmacy are stored securely until collected by the pharmacy. Medication fridge’s are monitored weekly (records sighted). Oxygen, suction and emergency trolley in the hospital unit is checked and signed off (as sighted). There are no gaps identified on the 18 medication sighing sheets reviewed. PRN medications have the time of administration on the signing sheet. Controlled drugs are signed by two persons. There is an improvement required to ensure transcribing is avoided for non-packaged and PRN medications. Dietary supplements, antibiotics and short course have signing sheets. Alert labels include “look for second pack”, “short course medications” and “controlled drugs”.

Eighteen medication charts sampled (four special care unit, eight rest home, six hospital) record prescribed medications by residents’ general practitioner, including PRN medication and the indications for use. All medication charts have photo identification (dated) and allergies/adverse reactions documented.

D16.5.e.i 2; 18 Medication charts reviewed identified three monthly medication reviews signed by the attending GP.

##### **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 for regular, “odd time” medications and PRN medications. Three medication rooms are viewed (rest home, hospital and special care unit) and one medication cupboard (serviced apartments). All medications rooms are secure. Medications trolleys are locked. Contents are all within expiry dates and eye drops are dated on opening. Expiry dates of all medications are checked monthly.

There are no gaps identified on the 18 medication sighing sheets reviewed. PRN medications have the time of administration on the signing sheet. Controlled drugs are signed by two persons. Dietary supplements, antibiotics and short course have signing sheets. Alert labels include “look for second pack”, “short course medications” and “controlled drugs”.

**Finding:**

(i)There is no documented evidence of medications checked against the medication chart on delivery. (ii) There is transcribing on four non-packaged signing sheets (two special care unit and two rest home).

**Corrective Action:**

(i)Ensure medications are checked against the medication chart on delivery. (ii) Ensure there is no transcribing.

**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 company hotel services manager. The service employs a qualified chef Monday to Friday and the weekends. The chef is supported by a chef assistant and a morning and afternoon kitchen hand each day. There is a four weekly seasonal menu that has been designed and reviewed by a dietitian at organisational level. The chef receives a resident dietary profile for all new admissions and is notified of dietary changes following the six monthly review and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences are written up on the kitchen whiteboard. Normal, mouli and diabetic diets and gluten free diets are provided. Food is delivered in hot boxes to the kitchenettes and dining areas in each area and served from bain maries. Caregivers serve the meals and have a resident like/dislike list in each dining area. The chef plates and labels special diets. Nutritious snacks such as desserts, yoghurt, custard, biscuits and sandwiches are available over 24 hours for residents in the dementia unit. Staff are observed sitting with the resident when assisting them with meals.

The service has a large workable kitchen with a separate dishwashing area, baking, cooking and storage areas, a walk-in chiller, freezers and freezers, walk-in pantry, two combi ovens and gas oven. All foods are date labelled in the freezers and fridges. Dry goods in the pantry are sealed and date labelled. There is a three monthly clean of the large dry goods bins. Fridge and freezer temperatures are recorded daily and there is evidence of corrective action taken where temperatures are outside of the accepted range. Facility food fridges are monitored weekly. Hot food temperatures are recorded daily. Room temperatures are monitored. There is a cleaning schedule in place (sighted) which is signed off as duties are completed. Staff are observed wearing aprons, hats and gloves.

The kitchen equipment is on a planned maintenance schedule. The preferred supplier provides chemicals, safety data sheets and chemical safety training as required. Quality control checks are carried out on the dishwasher. Chemicals are stored safely in the kitchen.

There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal

Feedback on the service is received from resident and staff meetings, surveys and audits.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours

D19.2: Staff have been trained in safe food handling and chemical safety (June 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 1.4.1: 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 implemented policies to guide staff in waste management - Waste Management - general waste, Waste Management - medical, and Waste Management - sharps. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry, housekeeping and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly. Safety data sheets are available. Staff attended waste management and chemical safety in November 2013.

##### **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 building is currently operating under a certificate for public use (CPU) dated 25 July 2013, while awaiting the completion of serviced apartments and the gym. Building compliance checklists are being completed monthly and daily egress checks are completed (sighted). The service is divided into three floors with special care unit on the third floor, hospital second floor and rest home/ serviced apartments on the first floor. The maintenance team address any maintenance requests or call in contractors as required. There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists and electrical testing. All equipment was purchased new and not yet due for annual checks. There is a qualified horticulturist responsible for the grounds and gardens. The maintenance team attend the facility meetings which include maintenance and preventative maintenance. Hot water temperatures in resident areas are monitored monthly and stable between 42-44 degrees Celsius. An internal audit (March 2014) for water temperatures achieved 100%.

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

There is an outside area with shade and seating that is observed to have well maintained paths. The special care unit has an open courtyard with seating and raised herb and vegetable gardens.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, standing and lifting hoists, mobility aids, transferring equipment, sensor mats, electric beds, ultra-low beds, hospital level specialised lazy boy chairs on wheels and weighing scales.

E3.3e: There are quiet, low stimulus areas that provide privacy when required

##### **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:**

There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms have ensuites. Communal toilets are located near the lounges. Residents interviewed (four rest home and six hospital) confirmed their privacy is assured when staff are undertaking personal cares.

##### **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 are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. Residents are encouraged to personalise their bedrooms.

##### **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:**

Each area has an open plan lounge/dining area. There are other lounge areas, seating alcoves including a library area available for quiet private time or visitors. The communal areas. There is a separate dining area in the large open plan living area in the secure unit.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

##### **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 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. Laundry service audit for March 2014 showed 99% compliance and housekeeping hygiene 95%. Corrective actions or re-audit was not applicable. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are displayed in the cleaning cupboards and there is secure chemical storage areas. There are two laundry persons on each day. All linen and personal clothing is laundered on- site. The service has introduced a new initiative of heated labelling system for all clothing that is carried out by laundry staff. Individual named linen bags are being placed in the resident’s rooms so that clothing can be checked for name labels as they are sorted. The laundry and cleaning areas have hand-washing facilities. Cleaner’s trolleys are well equipped. All chemical bottles have the correct manufacturer’s labels. Housekeeping staff carry the chemical bottles in a caddy with them when cleaning bedrooms and ensuites. External contractors clean the carpets, vinyl and furnishings on a three monthly cycle and all windows as per schedule.

Residents (four rest home and six hospital) interviewed state they are happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing is treated with care and is returned to them in a timely manner. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal audits.

##### **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. Charles Fleming has an approved fire evacuation plan – letter dated 18 February 2014. Fire dills are scheduled for staff during induction and six monthly. The last fire drill was held 28 May 2014 and the previous drill was 15 November 2013. Smoke alarms, sprinkler system and exit signs in place. There are internal fire walls beside balconies; i.e.: serviced apartment balcony above entrance and second floor hospital lounge open sliding doors that face out to internal atrium. In the event of a fire these will ensure full closure of the area

As per Ryman policy, staff are required to complete emergency response training every two years and emergency procedures are included in orientation. There is a first aid trained staff member on every shift.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

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 hospital also includes the Austco call bell system. When residents ring a light shines outside their room, on a control panel and also goes to staff pages. The serviced apartments also include call bells in resident rooms and ensuites. Those residents assessed as requiring rest home level care in the serviced apartments are given a call bell pendant so that a call bell is always accessible. 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. A closed Circuit Monitoring System with a 4 or 6 screen split is 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 is under-floor heating throughout the facility and a DVS ventilation system in place. All rooms have external windows with plenty of natural sunlight. Resident bedrooms on the ground floor open out onto the atrium.

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

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 currently has three residents who have been assessed as requiring the use of a restraint (bedrails) two resident with enablers (bedrails). 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 enablers (two files reviewed) are required to be reflected in the care plan (link 1.3.6.1).

Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the restraint approval and review process. The clinical manager is the restraint officer. Types of restraint have been approved for use by the restraints committee. The service is able to evidence a successful trial of removal of restraint.   
Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice is included in the core competencies and dementia course modules. Staff have attended restraint in-service within the last year.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

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

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint coordinator is the clinical manager/registered nurse and was in the restraint role for six months at another facility prior to appointment at Charles Fleming. The overall responsibility for restraint is included in the care manager job description. The approved restraints (bedrails and lap belts) are documented in the restraint policy.   
Restraint and consent is in consultation/partnership with the resident (as appropriate) or whanau, the restraint coordinator, GP and another RN.   
There is provision for emergency restraint following consent from family/whanau.

Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies are documented on the behaviour chart of a resident with challenging behaviour. Staff complete incident forms and report any accidents/incidents to the RN/Restraint coordinator in regards to restraint use and these are discussed at the RN and management meeting and corrective actions initiated. Frequent fallers are identified through the accident/incident data collated. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised.

Each episode of restraint is monitored at pre-determined intervals (as per the long term care plan) depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated at least six monthly or earlier if required. The restraint monitoring form includes codes for care delivered throughout the restraint episode and this is recorded on the monitoring form. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed of three hospital residents with restraint identified observations and monitoring occurring within the prescribed timeframes documented on individual residents’ restraint assessment.

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

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

**Attainment and Risk:** 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 2.2.2: Assessment **(**HDS(RMSP)S.2008:2.2.2)

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

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

**Attainment and Risk:** FA

**Evidence:**

Restraint assessments are undertaken by the restraint officer or registered nurse in partnership with the resident and their family/whanau. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form and this completed in consultation and discussion with the resident/family/whanau and GP. Three resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and six monthly evaluations.  
All files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed by the Restraint coordinator and restraint committee.

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

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:  
(a) Any risks related to the use of restraint;  
(b) Any underlying causes for the relevant behaviour or condition if known;  
(c) Existing advance directives the consumer may have made;  
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;  
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  
(f) Maintaining culturally safe practice;  
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  
(h) Possible alternative intervention/strategies.

**Attainment and Risk:** 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 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed by the restraint co-ordinator at least six monthly or earlier if required as part of the three monthly medical review. Families are included in restraint review as part of the long term care plan review. Effective de-escalation strategies are reviewed by the restraint co-ordinator and restraint committee (hospital unit co-ordinator, infection control officer, hospital and GP).

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

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:  
(a) Only as a last resort to maintain the safety of consumers, service providers or others;  
(b) Following appropriate planning and preparation;  
(c) By the most appropriate health professional;  
(d) When the environment is appropriate and safe for successful initiation;  
(e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** 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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  
(a) Details of the reasons for initiating the restraint, including the desired outcome;  
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  
(c) Details of any advocacy/support offered, provided or facilitated;  
(d) The outcome of the restraint;  
(e) Any injury to any person as a result of the use of restraint;  
(f) Observations and monitoring of the consumer during the restraint;  
(g) Comments resulting from the evaluation of the restraint.

**Attainment and Risk:** 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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

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

**Attainment and Risk:** 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 2.2.4: Evaluation **(**HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed by the restraint co-ordinator at least six monthly or earlier if required as part of the three monthly medical review. Families are included in restraint review as part of the long term care plan review. Effective de-escalation strategies are reviewed by the restraint co-ordinator and restraint committee (hospital unit co-ordinator, infection control officer, hospital and GP).

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

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:  
(a) Future options to avoid the use of restraint;  
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;  
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);  
(d) Whether the desired outcome was achieved;  
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;  
(f) The duration of the restraint episode and whether this was for the least amount of time required;  
(g) The impact the restraint had on the consumer;  
(h) Whether appropriate advocacy/support was provided or facilitated;  
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;  
(j) Whether the service's policies and procedures were followed;  
(k) Any suggested changes or additions required to the restraint education for service providers.

**Attainment and Risk:** 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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

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

**Attainment and Risk:** 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 2.2.5: Restraint Monitoring and Quality Review **(**HDS(RMSP)S.2008:2.2.5)

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

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

**Attainment and Risk:** FA

**Evidence:**

Individual approved restraint is reviewed at least six monthly as part of the medical review and six monthly as part of the long term care plan review in consultation with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint officer. Incident/accidents are reviewed by the restraint officer. Corrective actions are monitored. There is a monthly restraint officer report (including the hours of restraint) is sent to head office. Restraint is discussed at all clinical and management meetings. Issues/concerns are discussed at the meetings (minutes sighted). Restraint use is linked to the Ryman Accreditation programme (RAP).

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

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

**Attainment and Risk:** 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:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is an IC responsibility policy that includes chain of responsibility and an IC officer job description. There is an implemented infection control programme that is linked into the quality management system. Infection control matters are integrated with the monthly health and safety meetings and the infection control committee includes a cross section of staff. The facility meetings – RAP committee, staff, registered nurse, full facility, management - also include a discussion and reporting of infection control matters. Information from these meetings is passed onto the staff meetings. The IC programme policy states that the IC programme is set out annually from head office and is directed via the RAP annual calendar. The annual review policy states IC is an agenda item on the two monthly head office health and safety committee. The facility has developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. There have been no outbreaks since the service opened.

##### **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.)*

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control committee is made up of a cross section of staff from areas of the service including; (but not limited to) the village manager, the clinical manager, an RN who is taking over the role of IC officer from the clinical manager; and maintenance. The infection control committee is combined with the health and safety committee. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.

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

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

**Attainment and Risk:** 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 3.3: Policies and procedures **(**HDS(IPC)S.2008:3.3)

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

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

**Attainment and Risk:** FA

**Evidence:**

There are comprehensive infection control policies that are current and reflect the Infection Control Standard SNZ HB 8134:2008, legislation and good practise. These are across the Ryman organisation and are current and regularly reviewed. The infection control policies link to other documentation and cross reference where appropriate. There are policies for IC management, b) implementing the IC programme, c) education, d) surveillance, and e) IC policies and procedures related to the prevention of transmission of infection.

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

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

**Attainment and Risk:** 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 3.4: Education **(**HDS(IPC)S.2008:3.4)

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control officer is responsible for coordinating/providing education and training to staff. The IC officer is a registered nurse who had recently picked up the role for the clinical manager. Both have completed appropriate IC training (including Bug Control: CM, and IPC: RN). The induction package includes specific training around hand washing and standard precautions and the CM and RN (i.e. IC officer) confirm the IC officer provides training both at orientation and on-going. Training on infection control was last provided October 2013. Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.

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

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

**Attainment and Risk:** 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 3.4.5 (HDS(IPC)S.2008:3.4.5)**

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

**Attainment and Risk:** 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 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 describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported to the combined infection control and health and safety meetings. Staff are informed through the variety of meetings held at the facility. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the RAP. The results are subsequently included in the village manager’s report. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

##### **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.)*