# Jean Sandel Retirement Village Limited

## Current Status: 12 June 2014

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

## General overview

Jean Sandel is a part of a wider village and provides care for up to 131 residents and occupancy during the audit was 106. Occupancy included 39 rest home residents in the rest home, 30 hospital and 15 rest home residents in the hospital, two rest home residents in the serviced apartments and 20 residents in the dementia unit.

Alterations have been made to the dementia unit and as a result, 11 resident rooms have been relocated and are now part of the hospital/rest home. Six of the 11 beds are occupied on the day of the audit and these rooms were assessed as part of this audit as suitable to provide dual services.

The village manager and clinical manager are new to the service since previous audit. The clinical manager is an experienced registered nurse and has previous aged care experience in another Ryman facility. The village manager has been with the service since November 2012 and is an experienced manager with a non –health care background.

Jean Sandel has addressed three of the five shortfalls from their previous certification around complaints documentation, meeting minutes’ documentation and medication management. Further improvements continue to be required around wound assessment and care plan interventions. This audit identified improvements also required around medication documentation, staff training and review of activity plans.

## Audit Summary as at 12 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 12 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 12 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 12 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 low risk. |

### Safe and Appropriate Environment as at 12 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 12 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 12 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. |

# 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:** | Jean Sandel Retirement Village Limited |
| **Certificate name:** | Jean Sandel Retirement Village Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Jean Sandel Retirement Village | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care) | | | |
| **Dates of audit:** | **Start date:** | 12 June 2014 | **End date:** | 13 June 2014 |

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

11 beds from the dementia unit have been removed from the secure unit and added to the hospital/ rest home wing and these rooms are assessed as suitable to provide dual services.

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 106 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 14.00 | **Hours off site** | 6.00 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 14.00 | **Total hours off site** | 4.00 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 2 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 28 | Total audit hours off site | 12 | Total audit hours | 40 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 8 | Number of staff interviewed | 12 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 7 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 16 | Total number of staff (headcount) | 125 | Number of relatives interviewed | 8 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed |  |

## Declaration

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

I confirm that:

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

Dated Friday, 25 July 2014

## Executive Summary of Audit

**General Overview**

Jean Sandel is a part of a wider village and provides care for up to 131 residents and occupancy during the audit was 106. Occupancy included 39 rest home residents in the rest home, 30 hospital and 15 rest home residents in the hospital, two rest home residents in the serviced apartments and 20 residents in the dementia unit.

Alterations have been made to the dementia unit; as a result 11 resident rooms have been relocated and is now part of the hospital/rest home. Six of 11 beds are occupied on the day of the audit and these rooms were assessed as part of this audit as suitable to provide dual services.

The village manager and clinical manager are new to the service since previous audit. The clinical manager is an experienced registered nurse and has previous aged care experience in another Ryman facility. The village manager has been with the service since November 2012 and he is an experienced manager with a non –health care background. Jean Sandel has addressed three of the five shortfalls from their previous certification around complaints documentation, meeting minute’s documentation and medication management. Further improvements continue to be required around wound assessment and care plan interventions. This audit identified improvements also required around medication documentation, staff training and review of activity plans.

**Outcome 1.1: Consumer Rights**

Open disclosure principles are implemented and resident and family interview confirmed that open communication is maintained. The management have an open door policy and are always available to discuss issues of any nature. Complaints register is up to date and a separate log is maintained for each area. All complaints included evidence of complaints acknowledgments including written follow up letter and evidence of resolution. This is an improvement since the previous audit.

**Outcome 1.2: Organisational Management**

Jean Sandel has a well-established quality and risk management system that is directed by Ryman head office. The Ryman Accreditation programme (RAP) sets annual objectives both at national and facility level. The RAP focuses on provision of quality services, maintenance of a safe environment, delivery of culturally appropriate care and the minimisation of risks of unwanted events. All quality data and information from the RAP is reviewed by Ryman clinical auditor on a monthly basis. Consequently exception reports are completed and any areas of risks are highlighted and communicated to the operations team monthly. This report is also presented at the clinical advisory committee meetings. Resident and family satisfaction surveys are completed and both show satisfaction with the services above the Ryman average.

The orientation/induction programme is implemented. The annual training programme well exceeds eight hours annually. Clinical and leadership training is provided to all relevant staff. There is a registered nurse/enrolled nurse journal club directed by head office whereby articles, research and questions are discussed.

There is a policy for determining staffing and skill mix for safe service delivery. Staff identified that staffing levels are good and staffing hours increased as needed. Review of staff records provides evidence of human resources processes being followed and individual education records are maintained. There is an improvement required around completion of dementia care training for staff who work in the special care unit.

**Outcome 1.3: Continuum of Service Delivery**

The registered nurse is responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required around the documentation of interventions and aspects of wound assessment. The previous shortfall around the documentation of interventions remains.

Resident files are integrated and include notes by the GP and allied health professionals. The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the resident group. Spiritual and cultural preferences and needs are being met. There is an improvement required around the review of the activities plan. Education and medicines competencies are completed by all staff responsible for administration of medicines. Medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification and special instructions for administration. There are improvements required around the documentation of allergies on the medication charts. The previous shortfall around medication documentation has been addressed.

Food services and all meals are provided on site and transported to the hospital and special care unit in hot boxes. Resident’s individual food preferences and dislikes are known by staff serving the meals. There is dietitian review of the menu. All staff are trained in food safety and hygiene. There are nutritious snacks and finger foods available in the special care unit 24 hours.

**Outcome 1.4: Safe and Appropriate Environment**

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

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

Clinical manager is the restraint coordinator. On both days of the audit, there are no residents using enablers and three residents are using bed rails as restraint in the hospital. Restraint/enabler register reviewed evidenced on-going monitoring of restraint. Training has been provided to staff around restraint minimisation, enablers and challenging behaviours.

**Outcome 3: Infection Prevention and Control**

The surveillance programme is implemented via Ryman RAP calendar. All infections are collected via the infection report form and discussed at the RAP meetings. Following this the report information is entered onto the Vcare system and a collated report is generated by the head office. Trends and individual outcomes are noted and acted upon by Jean Sandel. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 12 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 35 | 0 | 4 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | E4.5f; There are 12 caregivers in the SCU. Three caregivers who have been working in the unit over 12 months have not completed the required dementia standards and three are in the process of completing the standards who are employed less than a year. | Ensure that staff who work in the SCU complete required qualifications within identified timeframe. | 180 |
| 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 | 1) The hospital wound log is not current. There are five wound assessments incomplete in the hospital unit as follows; two wounds have no documented type of wound, there is no size for one leg wound and no monitoring of wound size for two wounds. One skin tear in the rest home has not been evaluated every two days as instructed. There is no size documented for one heel pressure areas (grade 3) and one sacral pressure area (grade one) in the hospital. There are no pressure area interventions documented in the care plan for one hospital resident with grade one sacral pressure area. 2) One hospital resident with a weight loss of 3.3kg in one month (April 2014) and a nutritional score of three does not have a weight loss plan in place. There is no evidence of GP consultation. A second hospital resident with weight loss does not have weight loss interventions updated on the long term care plan following six monthly written evaluation and GP visit. The high calorie dessert list in the kitchenette is updated on the day of audit. 3) There is no behaviour assessment or behaviour nursing care plan (including early warning signs and symptoms) in place for rest home resident following two incidents of altered behaviour (February 2014). | (i)Ensure wound care documentation is fully completed; (ii) ensure interventions reflect current health needs | 90 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | ARC 16.5ciii: The activity care plan is not reviewed at the same time as the care plan review. | Ensure the activity plan is reviewed at the same time as the care plan review | 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 Low |  |  |  |
| 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 Low | Four out of 14 medication charts did not have an adverse reaction documented. The sample was extended by another two charts. Seven out of 16 medication charts did not have an allergy status documented. | Ensure the allergy status is documented on the medication chart. | 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 1.1.9: 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:**

Policies and procedures have been documented to ensure the open disclosure of all information particularly in response to incidents/accidents and adverse events. Review of 16 incident and accident reports (five hospital, six rest home and five dementia) demonstrate clear information detailing that the residents and/or family members had been informed and consulted.

Residents interviewed (five rest home and three hospital) stated that the management has an open door policy and is always available to discuss issues of any nature. Complains are followed up and feedback given to the complainant. Seven files reviewed (three hospital and two each rest home and dementia) confirm evidence of family notification of adverse events in the progress notes.

Seven resident files (three hospital, two rest home and two dementia) reviewed included signed admission agreements on the date of admission.

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 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 Family members interviewed (three rest home, three hospital and two special care unit (SCU), stated that they are always informed when their family members health status changes.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Complaints information is provided at entry to the service and complies with right 10 of the Code. The complaint process is displayed in a format that is readily understood and accessible to residents and families. They are supported by staff to discuss the complaint process. Family interviews confirmed (three rest home, three hospital and two SCU) that complaint process is accessed and staff were responsive to any complaints and encourage families to discuss any issues with the management.

The village manager stated that complaints are entered on the patient management software (Vcare), as an event to analyse levels of resident dissatisfaction and monitor trends.   
There is a complaints register that is up to date and a separate log is maintained for each area. The complaints register for 2013 records four written complaints in the rest home. There are four complaints registered for the hospital. All complaints are investigated and resolution is noted in the complaints register. Staff interview confirmed knowledge about these complaints. There is an evidence of quality improvement which is linked to the care planning and service delivery. There are no complaints documented for the dementia log. All complaints included evidence of complaints acknowledgments including written follow up letter and evidence of resolution. This is an improvement since the previous audit.

Staff in-service education in relation to complaints was conducted in February and March 2014 and attended by 64 staff.  
The village manager reports that there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, Police, Accident Compensation Corporation (ACC) since the previous audit at this facility. There is one coronial investigation still awaiting outcome.

D13.3h. A complaints procedure is provided to residents within the information pack at entry.

E4.1biii.There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including 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 minimising restraint, behaviour management and management of complaints.

##### 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:**

Jean Sandel is a part of a wider village and provides care for up to 131 residents and occupancy on both days of the audit were 106. Occupancy included 39 rest home residents in the rest home, 30 hospital and 15 rest home residents in the hospital and two residents in the serviced apartments. Four of the rest home residents are receiving respite care on both days of the audit. The SCU has 22 bed capacity and occupancy is at 20.

The SCU unit has dropped from 33 to 22 bed capacity and these 11 beds are added to the hospital /rest home services. Six of 11 beds are occupied on day of the audit, and these rooms are assessed as suitable to provide dual services.

There are 20 certified serviced apartments and two residents in the apartments are receiving rest home level care. Jean Sandel is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care.

Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. To monitor organisation performance, the manager reports weekly to head office and the Ryman Accreditation program (RAP) committee meetings occur monthly. There are organisational quality objectives and quality objectives specific to Jean Sandel. The village objectives are as follows a) improve dining experience b) improvement in education and induction programme, c) increased activities across the village, and d) elimination of back injuries. Progress reporting of each objectives are documented.

The village manager has been in this role since November 2012. He has many years of experience in non-health related management field. The manager has completed specific manager orientation with Ryman. The manager is supported by the clinical manager (RN) that has been in this role since April 2013. She was transferred from another Ryman Healthcare facility and had been in the Ryman healthcare for six years. She is an overseas trained registered nurse with 25 years of experience in health and disability sector. She has completed several clinical and the leadership/management training organised by the Ryman Health Care. She works full time and is supported by RNs and the clinical coordinator at the SCU. The village manager advised that the service is in progress of recruiting a hospital coordinator. The village manager is supported by the human resource manager/assistant manager who is responsible for rosters, laundry, housekeeping, assisting with human resources and appointments of non-clinical staff.   
The management team is also supported by the Ryman management team including the regional manager and the managing director.

ARC E2.1: The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

ARC,D17.3di (rest home), D17.4b (hospital): The village manager has maintained at least eight hours annually of professional development activities relating to managing an aged care facility.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Jean Sandel has a well-established quality and risk management system that is directed by Ryman head office. RAP focuses on provision of quality services, maintenance of a safe environment, delivery of culturally appropriate care and the minimisation of risks of unwanted events. Operations procedures are routinely reviewed as part of the RAP program and the head office has started a routine spot auditing including all aspects of policy compliance. The last spot audit completed by Ryman head office for Jean Sandel completed in March 2014 and required corrective actions that are signed off on 30 April 2014.

The village RAP committee develops and implements special annual objectives for quality improvements that reflect their village’s quality programme, feedback from the previous year for example, audit results, resident and family satisfaction surveys, relevant sentimental events analysis and incident and accidents trends.

The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Jean Sandel at the onsite monthly RAP meetings (which are attended by all staff) and weekly management meetings. A RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme.

Comprehensive monthly accident/incident reports are completed which break down the data collected across each area in the facility. Reports are provided from the village manager to head office that includes a collation of staff incidents/accidents and resident incidents/accidents. The internal auditing annual schedule is implemented as per schedule.

All complaints are attended to through the monthly RAP meeting. Quality improvement plans are initiated where required.

All infections are documented in a monthly summary report and discussed in the monthly RAP committee meetings, and monthly health and safety/IC meetings.

The restraint approval group meeting at Jean Sandel is held six monthly with minutes documented. An internal audit is completed six monthly.

Discussions with two registered nurses, four caregivers (who work across rest home, hospital and SCU), a diversional therapist and review of meeting minutes demonstrate staff involvement in quality and risk activities.

Resident meetings are held on a two monthly basis in the rest home and in the hospital. Relative/family meetings are held six monthly for the all areas of the service. Minutes are maintained.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar.

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

Resident satisfaction survey was last completed in December 2014. 27 residents responded and showed 97% satisfaction (Ryman average is 94%).

Relative’s survey was last completed in February 2014 and the result showed 94% satisfaction (Ryman average is 90%).

Meeting minutes including staff meetings and the RAP committee meetings include responsibilities, corrective actions, resolutions and timeframes. This is an improvement since the previous audit. Quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement.

Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. Risk management, hazard control and emergency policies and procedures are in place. Hazard identification and control occurs and a hazard register is in place. On-going hazards are identified through health and safety meetings.

There have been some changes made to the Ryman benchmarking programme. The village manager stated that the six monthly incident and accident comparison data is removed from the audit schedule and it is superseded by the clinical indicator monthly report. Village managers have access to the clinical indicators in their village including a report of average score over a six month period for each village. This will start by July 2014. Currently all quality data and information from the RAP is reviewed by Ryman clinical auditor on a monthly basis. Consequently exception reports are completed and any areas of risks are highlighted and communicated to the operations team monthly. This report is also presented at the clinical advisory committee meetings which meet quarterly. Review of the quality data reveals that number of falls exceeded the clinical indicator reference range of 11 in the hospital wing. Hospital residents had 14 falls over a three days 28-31 May 2014, a trend in the time of falls between 7.00-9.00, 12.15-13.00, 15.00-16.00 and 19.00hrs. The following interventions have been implemented as evidenced by review of care plans and discussions with the clinical manager. The resident is transferred to the nearest room to the nurse’s station, low bed, soft tech role guard and a mattress next to the residents’ bed is provided. Care plans highlights staff to use distraction techniques.

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

D19.2g fall prevention strategies such as post falls assessments, grip cushions, soft tech roll guards, high low beds and sensor mats are in use.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The management team is aware of their responsibility for essential notification. Review of infection control program and interview with the village manager and the clinical manager confirmed this. The Public Health department was notified in April 2014 of a gastro-intestinal outbreak.

Jean Sandel documents and analyses incidents/accidents, unplanned or untoward events, and provides feedback to the service and staff so that improvements are made. A review of incident/accident forms identifies that they are fully completed and include follow-up actions. A falls response protocol was completed where appropriate, including neurological observation when a resident has hit their head.

Incident and accidents forms are data entered into Vcare and then are filed in residents files. 16 incident/accidents are reviewed for March 2014. In the rest home, all six accident/incident reports are related to a fall incident. One of these incidents was fall with injury. Document review of the resident file revealed that the falls response protocol is completed including pain assessment and neurological observations. GP notification occurred and subsequently the resident’s care plan is reviewed and updated. In the Special care unit (SCU), five incident and accident forms are reviewed, two incidents are related to fall and three of them are skin tears. All had appropriate follow ups, and skin tears are minor and healed. In the hospital, incident and accident forms related to two falls and three skin tears (one of these were self-inflicted) are reviewed. All had appropriate follow ups, and following three of these incident reports, new nursing assessments are completed and care planning interventions are changed accordingly.

Minutes of the monthly RAP committee meetings, two monthly health and safety meetings and monthly full facility meetings reflect a discussion of incidents/accidents and actions taken.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Staff education and training include the aged care education (ACE) programme for caregivers. Ryman head office provides the facility with resources to support the in-service programme monthly. There is an implemented education plan (sighted for 2013 and 2014). The annual training programme well exceeds eight hours annually.

Clinical and leadership training is provided to all relevant staff. There is an improvement required around dementia specific training.

D17.7d: There are implemented competencies for registered nurses relating to specialised procedures i.e. medication competency, insulin competency, and warfarin competency.

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

Registered nurses are supported to maintain their professional competency. Staff training records are maintained registered nurses/enrolled nurses participate in the Ryman nursing journal club that meets monthly.

On-going staff comprehension questionnaires are completed throughout the year, as part of on-going education and competency assessment. There are comprehension surveys for all staff (health & safety, fire, emergency procedures, on call, house rules, incidents, infection control, privacy, abuse and neglect, communication and complaints). There are also specific comprehension surveys for care staff, food service staff, registered nurses and enrolled nurses. The medication knowledge comprehension survey is conducted twice a year for staff that administer medicines.  
A review of 10 staff records (one clinical manager, one clinical coordinator, one diversional therapist, one chef and six caregivers) showed that human resource processes are followed and are completed. An appraisal schedule is in place and current staff appraisals are sighted in all staff files reviewed.

An orientation/induction programme is available and all files reviewed had evidence of completion of the orientation program.  
There are job descriptions available for all positions and employment contracts are in place.  
A register of registered nurse practising certificates is maintained within the facility. The current general practitioners' registration is printed from the professional body's website.

##### 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:** PA Low

**Evidence:**

All caregivers are encouraged and supported to complete the Aged Care Education (ACE) foundations within a one-year time frame.

**Finding:**

E4.5f; There are 12 caregivers in the SCU. Three caregivers who have been working in the unit over 12 months have not completed the required dementia standards and three are in the process of completing the standards who are employed less than a year.

**Corrective Action:**

Ensure that staff who work in the SCU complete required qualifications within identified timeframe.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Staffing levels and skills mix policy documents the rationale for safe service delivery. The policy records staffing ratios to residents in the hospital, rest home and SCU and service apartments. Rosters reviewed evidence implementation of the documented staffing and skills mix rationale.   
Registered nurse cover is provided 24 hours a day, seven days a week. The rest home and hospital are coordinated by the clinical manager and the SCU has dedicated clinical coordinator (RN). The serviced apartments are co-ordinated by the service apartment’s co-ordinator who is an enrolled nurse and works Tuesday to Saturday. The clinical manager is also rostered one day on weekend. The staff in the care centre care for the rest home residents in the serviced apartments after 6.30 pm daily. Call bells in the serviced apartments are linked throughout the facility. The village manager is on call at all times as a first point of call and all clinical issues are reported to the clinical manager.

Interviews with four caregivers and two registered nurses state that overall the staffing levels are good although they are kept very busy. The roster has been adjusted as resident numbers increase. Staff particularly commented on the appointment of DT in SCU and stated that residents are now more engaged with the activities offered. Relatives interviewed (eight) stated that staffing level is up to the aged care standards and staff work very hard to meet residents’ needs.

Staffing is as follows:

One village manager (09:00-17:30 Mon-Fri), and 1x clinical manager (RN) (08:00-16:30 Sun-Thurs).

There is registered nurse cover on every shift.

In the rest home (39 rest home residents).

am

1xRN/EN (07:30-16:00 Mon-Sun), 2xCG (07:00-15:30 Mon-Sun), 2xCG (07:00-13:00 Mon-Sun).

pm

2xCG (15:15-23:15 Mon-Sun), 1xCG (16:00-21:00 Mon-Sun).

Night

2xCG (23:00-07:00 Mon-Sun).- The RN in the hospital oversee the rest home.

In the serviced apartments (two rest home residents).

am

1xRN on call, 1xSA coordinator (08:00-16:30 Tues-Sat), 1xCG (07:00-15:00 Mon-Sun), 1xCG (07:30-13:00 Mon-Sun), 1xCG (07:00-15:30 Sun-Mon).

pm

1xRN on call, 1xCG (16:30-21.00 Mon-Sun).

Night

1xRN on call.

In the hospital (30 hospital and15 rest home residents).

am

2xRN (07:00-15:30 Mon-Sun), 3xCG (07:00-15:00 Mon-Sun), 2xCG (07:00-15:30 Mon-Sun), 2xCG (08:00-13:00 Mon-Sun), and 1xCG(07.00-13.00)

1x Fluid/servery assistant- 09:00-13.00), 1x Physio assistant 9-12 (5x a week)

pm

1xRN (14:45-23:15 Mon-Sun), the Roster is increased to the two RN on pm duties and the second RN is orientating on the day of audit.

2xCG (15:15-21:00 Mon-Sun), 1xCG (15:15-23:15 Mon-Sun), 1xCG (16:30-23:00 Mon-Sun), 1xCG(16:30-21:00), 1xCG(16:30-20:30)

Night

1xRN (22:45-07:15 Mon-Sun), 2xCG (23:00-07:00 Mon-Sun).

The village manager advised that the service is in progress of recruiting another caregiver for the night duty.

In the SCU (20 residents).

am

1xclinical coordinator (07:30-16:00 Tuesday to-Sat), 1x RN (Sunday-Monday)

1xCG (07:00-15:00 Mon-Sun), 1xCG (07:00-15:30 Mon-Sun), 1x activities coordinator (09:30-16:30 Mon-Sun).

pm

1xRN on call, 1xsenior CG (15:00-23:00 Mon-Sun), 1xCG (15:30-23:00 Mon-Sun), 1xCG (16:00-20:30 Mon-Sun).

Night

1xRN on call, 2xCG (23:00-07:00 Mon-Sun)

Three laundry staff and four housekeeping staff are rostered for the care centre.

There are one chef, two cook assistants and two kitchen assistants that provide food services. The maintenance staff works full time and there are one diversional therapist and two activities coordinators for the care centre.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service provides rest home, hospital and dementia levels of care. Eleven SCU rooms have been reconfigured to hospital level rooms by relocation of secure doors of the SCU. The rooms viewed are all ensuited, spacious enough to deliver hospital level care with the use of a hoist if required and have an operational call bell system. The wing of 11 beds is closely located to the nurse’s station. These rooms are assessed as suitable to provide rest home or hospital level care.  
The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy. The nursing care assessment and service delivery policy and nursing care assessment and planning interventions policy describes the responsibility around documentation. Activity assessments and activities plans have been completed by the diversional therapist and activity officers.

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

D16.2, 3, 4; An initial assessment is completed within 24 hours, initial care plan within 48 hours and long term care plan within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. Seven resident files were reviewed (two rest home, two dementia care and three hospital). All seven long term files had the initial admission assessments and plans and the long term care plan completed by the registered nurses within the required timeframe. Six monthly evaluations are completed within six months in four of the seven files. Two hospital and one rest home resident have not been at the service for six months.

D16.5e; Medical assessments are documented in all seven long term files within 48 hours of admission. Three monthly medical reviews are documented in five of seven files by general practitioner. Two residents are not due for a three monthly medical review. More frequent medical assessment/ review is noted occurring in residents with acute conditions and those requiring palliative care. The service has a contracted GP who visits twice weekly and is available at other times to visits residents of concern. The GP is unavailable for interview on the day of audit.

The staff interviewed (four caregivers - one rest home, two hospital, one special care unit) could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Duty handover sheets note any residents requiring any special observations or needs. There is an additional handover for staff starting at 4pm. Serviced apartment staff handover to rest home staff at 9 pm. Progress notes are maintained at least daily for rest home and each shift for hospital residents or more frequently as required. Seven files reviewed evidence this is occurring.

The physiotherapist conducts an initial resident mobility assessment on admission. A resident safe handling chart is then developed as evidenced in the three hospital level resident files reviewed. The registered nurses, refers any resident mobility/falls concerns to the physiotherapist. The physiotherapist provides education for staff in safe manual handling and practical demonstrations last attended in March 2014 (23 staff).

Tracer methodology hospital resident.

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

Tracer methodology rest home resident.

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

Tracer methodology resident in special care unit

*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 1.3.6: 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:**

Seven resident files were reviewed (two rest home, two special care unit, three hospital). Residents interviewed (five rest home, three hospital) report their needs are being appropriately met. Relatives interviewed (three rest home, three hospital and two special care unit) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. Assessment tools completed on admission include, a) full nursing assessment, b) waterlow pressure area risk assessment, c) three day continence diary, d) mobility assessment e) coombes falls risk, f) nutritional assessment as applicable, g) pain assessment, h) wound assessment, and i) behaviour assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. There is an improvement required around wound assessments/evaluations and documentation of pressure area interventions.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager and two RN's interviewed. Continence management education was provided in March 2014 (26 staff).

Weight loss short term care plans available for use include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/Dietitian notification. There is an improvement required around the documentation of weight loss interventions.

Behaviour assessments are completed on admission for two of two special care unit resident files reviewed. There is an improvement required around interventions for altered behaviour (rest home resident).

##### 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:**

Wound assessment and treatment plan and evaluations are in place for four wounds, one skin tear one sacral pressure area (grade 1) and one heel pressure area (grade 3) in the hospital unit. There are four skin tears, one wound and one sacral pressure area (grade 2) in the rest home and one ankle ulcer rest home resident in serviced apartment. There are no wounds, skin tears or pressure areas in the special care unit. There is evidence of GP notification for non-healing wounds and pressure areas. Seven RNs attended skin care January 2014, 27 staff attended skin tear in-service February 2014 and the monthly journal club for March 2014 was on pressure area care.

Calibrated chair scales and wheel-on scales are used to weigh residents monthly. Weight loss short term care plans available for use include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/Dietitian notification. The resident dietary requirements are reviewed and a copy sent to the kitchen. A dietitian is available as required. Food and fluid monitoring charts are evidenced in use.

Behaviour assessments are completed on admission for two of two special care unit resident files reviewed. A behaviour nursing care plan is in place that identifies the type of behaviour, triggers/causes and management over a 24 hour period including activities and de-escalation/distractions. Behaviour charts are in use for new or altered behaviours.

**Finding:**

1)The hospital wound log is not current. There are five wound assessments incomplete in the hospital unit as follows; two wounds have no documented type of wound, there is no size for one leg wound and no monitoring of wound size for two wounds. One skin tear in the rest home has not been evaluated every two days as instructed. There is no size documented for one heel pressure areas (grade 3) and one sacral pressure area (grade one) in the hospital. There are no pressure area interventions documented in the care plan for one hospital resident with grade one sacral pressure area. 2) One hospital resident with a weight loss of 3.3kg in one month (April 2014) and a nutritional score of three does not have a weight loss plan in place. There is no evidence of GP consultation. A second hospital resident with weight loss does not have weight loss interventions updated on the long term care plan following six monthly written evaluation and GP visit. The high calorie dessert list in the kitchenette is updated on the day of audit. 3) There is no behaviour assessment or behaviour nursing care plan (including early warning signs and symptoms) in place for rest home resident following two incidents of altered behaviour (February 2014).

**Corrective Action:**

(i)Ensure wound care documentation is fully completed; (ii) ensure interventions reflect current health 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:** PA Low

**Evidence:**

There is a qualified diversional therapist (DT) and three activity officers that provide separate activity programmes for the rest home and hospital and dementia unit seven days a week.

The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are displayed on notice boards around the facility. There is a core programme which includes the triple A (Active, Ageless, Awareness) exercise programme that was designed by the Ryman group and includes exercises for less active residents and a more active exercise programme for mobile residents and serviced apartments. Triple A programme in the dementia unit also includes meaningful activities for the resident such as folding washing, dusting and knitting. Other activities in the units are delivered to meet the cognitive, physical, intellectual and emotional needs of the consumer group. Activities include (but not limited to); newspaper reading, board games, floor games, discussion, reminiscing, arts and crafts, baking, pampering activities such as nail care, walks, movies and happy hours. Entertainers and guest speakers visit the service. Residents are encouraged to maintain community links with such groups as inter-home visits, RSA, card groups and knitters and weavers clubs. There are weekly outings for the three units. The service has two vans and the Ironside wheelchair van is accessed for hospital residents in wheelchairs. Weekly contact is made with residents who choose not to participate in the group programme and one on one time is spent with them. One on one time, individual activities and small group activities is part of the programme in the special care unit. Church services are held fortnightly in the chapel and on Sundays for Catholic communion.

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, ‘your life experiences'. The activity plan is reviewed six monthly by the DT/activity co-ordinator with the resident/family and registered nurse.

The activity plan includes headings for comfort and wellbeing, outings, interests and family and community. A resident attendance list is maintained for activities, entertainment and outings.

Resident meetings are held bi-monthly and feedback to activities is provided at the meeting. Relative meetings are held six monthly with an invitation to attend happy hour. Resident and relative surveys provide feedback on the activity programme.

All eight (five rest home and three hospital) residents interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d Seven resident files reviewed identified there is an improvement required around the review of the activity plan and care plan review to occur at the same time.

##### 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:** PA Low

**Evidence:**

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences'. The activity plan is reviewed six monthly by the DT/activity co-ordinator with the resident/family and RN.

**Finding:**

ARC 16.5ciii: The activity care plan is not reviewed at the same time as the care plan review.

**Corrective Action:**

Ensure the activity plan is reviewed at the same time as the care plan review

**Timeframe (days):** 90 *(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. Four of seven resident files sampled (one rest home, two special care unit and one hospital) contained written evaluations completed six monthly. One rest home resident and two hospital residents have not been at the service six months. Short term care plans in place evidence regular evaluations with on-going problems transferred to the long term care plan. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The service uses individualised medication blister packs for regular and prn medications. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. The medications are delivered monthly and checked against the medication charts by a RN and the clinical manager. Any discrepancies are fed back to the pharmacy. The medication trolleys are kept in locked treatment rooms in the rest home, hospital and special care unit. RN's in the hospital and senior caregivers in the rest home and special care unit are competency assessed annually (January 2014) and responsible for administering medication. Medication education was completed in February 2014. RN's complete syringe driver training and annual refreshers at the hospice. Controlled drugs are stored in a locked cabinet in the hospital, rest home and special care unit. Controlled drugs for the serviced apartments are kept in the rest home drug safe. There are weekly controlled drug checks and six monthly pharmacy audit of controlled drugs. Standing orders in use are current. There are no self-medicating residents. Two medication competent persons sign for the administration of controlled drugs. Administration signing sheets are correct and complete. PRN medications administered have a date and time of administration recorded. Expiry dates are checked monthly. Eye drops are dated on opening. Medication fridge temperatures are monitored weekly. Emergency oxygen ad suction is checked weekly.

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. Medication charts have photo identification. Four out of 14 medication charts did not have an adverse reaction documented. The sample was extended by another two charts. Seven out of 16 medication charts did not have an allergy status documented. There is an improvement required around the documentation of allergy status on the medication chart.

D16.5.e.i.2; Fourteen medication charts reviewed (four special care unit, four rest home and six hospital) identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

Internal medication audit conducted April 2014 identified corrective action around PRN medications. A re-audit was completed in May 2014. Medication and insulin competency audits in January 2014 achieved 100%.

##### 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 Low

**Evidence:**

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. Medication charts have photo identification.

The previous shortfall around medicine management and documentation has been addressed.

**Finding:**

Four out of 14 medication charts did not have an adverse reaction documented. The sample was extended by another two charts. Seven out of 16 medication charts did not have an allergy status documented.

**Corrective Action:**

Ensure the allergy status is documented on the medication chart.

**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 qualified chef Monday to Friday and a weekend chef. The chefs are supported by two kitchen hands on the morning shift and an afternoon kitchen hand. The four weekly seasonal menu is designed and reviewed by a registered dietitian at an organisational level. All meals and morning teas are cooked on site. The hot meal is at midday with a lighter tea. The cook receives a resident dietary needs form for each resident on admission and is notified of any changes to dietary requirements such as soft, pureed or modified diets or any resident with weight loss. Likes, dislikes and special diets are written up on the kitchen whiteboard. Alternative meals are offered for those resident with dislikes or religious preferences. Currently the chef accommodates gluten free, dairy free and food allergies. Residents have a “special choice” on Wednesdays. Menus are displayed on the dining room boards. Normal, soft, pureed and finger foods are provided as per the resident diet profile. High protein and high calorie foods, protein shakes, smoothies and desserts are provided for residents with weight loss. Diabetic residents have a normal meal with smaller desserts and sandwiches are readily available from the kitchen. Nutritious snacks and “food on the run” finger foods are available 24 hours in the special care unit. Gas hobs and two combi ovens are used for the cooking of meals. Meals are delivered to the hospital and special care unit in hot boxes and served from the bain maries by care staff. Special diets are plated and labelled.

The service has a large workable kitchen with a separate area for dishwashing, food preparation and cooking. There is a large walk-in chiller, fridges and two freezers and a dry goods storage area. All dry goods are in sealed containers, labelled and off the floor. Stock is rotated when goods are delivered.

The chiller temperature is recorded daily. The freezers temperatures are recorded monthly and there is visual temperature monitoring. Hot food temperature monitoring is completed twice daily on the midday and evening meals. Staff are observed wearing correct personal protective clothing. Chemicals are stored safely. Cleaning schedules are maintained with walls and ceilings cleaned by a contracted service.

Eight residents interviewed (five rest home and three hospital) are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys. There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets. Food temperature audits are completed six monthly. There was a 100 % compliance in January 2014.

D19.2 Eleven staff attended safe food handling in May 2014.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The building holds a current warrant of fitness which expires on 21 May 2015. The service employs a maintenance officer for the facility and town houses. Preventative and planned maintenance is carried out. Contractors are called in as required. Building maintenance is carried out when necessary and records maintained. Water temperatures are monitored across all areas and adjustments are made when the temperature is above/below 45 degrees. There is access to necessary and essential equipment. Medical equipment including hoists are checked and/or calibrated annually. The maintenance officer is currently undergoing electrical testing training and a full electrical equipment check is scheduled.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## 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:**

Clinical manager is the restraint coordinator. On both days of the audit, there are no residents using enabler and three residents are using bed rails as restraint in the hospital. Restraint/enabler register reviewed evidences on-going monitoring of restraint.

Restraint /enabler and de-escalation training was provided in January 2014 and in addition to that a restraint case study was provided in May 2014.   
Staff interviews confirm knowledge around restraint minimisation and enablers. Current restraint competencies are sighted in staff files sampled.   
E4.4a the care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. Education on managing challenging behaviours last occurred in May 2014 and was previously provided in March 2014.

##### 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.)*

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The surveillance program is implemented via Ryman RAP calendar. All infections are collected via the infection report form and discussed at the RAP meetings. Following this, the report information is entered onto the Vcare system and a collated report is generated by the head office. Trends and individual outcomes are noted and acted upon by Jean Sandel. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents.

Internal audits are completed and communicated to the staff via RAP meetings on a monthly basis and handover meetings on a daily basis. Review of minutes of RAP meetings shows that IC surveillance activities are communicated to staff. Staff interview also confirm this. The infection control training is provided to the staff in January 2014 and second training was provided following the outbreak in April 2014.

Jean Sandel had a gastro outbreak in the care centre including all areas of the service but serviced apartments in April 2014. Review of the outbreak management report showed that Public Health Services are notified and the infection control and prevention interventions are implemented. Daily communication with the staff, residents and families are noted and terminal cleaning was conducted after the outbreak. There is an evidence of support from the Ryman head office by way of additional resources and expertise.

##### 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.)*