

Kiri Te Kanawa Retirement Village Limited

Current Status: 18 August 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

Ryman Kiri Te Kanawa is owned by Ryman Healthcare. The service has capacity for up to 127 residents including providing rest home level care in 30 serviced apartments. On the day of the audit there were 67 residents: 38 residents receiving rest home level care including five in serviced apartments, 26 residents receiving hospital level care and three residents in the dementia unit. One 12 room rest home wing is available for use but has not yet opened. The manager is new to the service and is currently undergoing a comprehensive orientation. He is supported by a clinical manager who has been at the service for two weeks and has six years' experience in Ryman aged care facilities. The regional manager has been overseeing the facility between managers. Families, residents and the general practitioner interviewed spoke very positively of the care provided.

This audit has identified areas requiring improvement around complaint documentation, self-medication documentation and weights for one resident.

Audit Summary as at 18 August 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

Indicator	Description	Definition
	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 18 August 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.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 18 August 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 18 August 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.
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Safe and Appropriate Environment as at 18 August 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.
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Restraint Minimisation and Safe Practice as at 18 August 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.
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Infection Prevention and Control as at 18 August 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.
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Audit Results as at 18 August 2014

Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and services provided, is fully available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Staff training takes place on an annual basis, reinforcing delivery of care based on the rights of the residents and their family/whanau and their freedom of choice. Care plans reflect these core values and interviews with residents and family/whanau are positive about the service understanding and implementing their values and beliefs.

There is a Maori health plan and supporting policies that acknowledge the Treaty of Waitangi. The plan identifies culturally safe practices for Maori and recognition of Maori values and beliefs. The Maori health plan identifies the importance of whanau and this is seen as a highlight of the service.

On-going staff development through education and in-service training is strongly supported and this enhances the quality and risk management programme. Training and the delivery of service, supports evidenced-based practice. There is an improvement required around complaint documentation.

Residents and family interviewed praised the care provided and Kiri Te Kanawa in general and they state that the quality has vastly improved with the employment of the new management team.

Organisational Management

Ryman has quality and risk management systems implemented across the facilities that are monitored by head office. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards.

The service at Kiri Te Kanawa is led by a village manager who is new to the role and currently undergoing a comprehensive orientation. He has a background in senior management roles in financial services and is supported by the assistant manager who has been formally in the role since April 2014, the clinical manager who is a registered nurse and the regional manager who has extensive experience in aged care.

Kiri Te Kanawa is implementing a quality and risk management system with meetings set up to discuss quality improvement data including incidents, accidents, complaints, health and safety and hazards. Internal audits are completed as designated by the programme schedule with evidence of corrective action plans completed with resolution documented. A continuous quality plan for 2014 is documented and reviewed quarterly with evidence of progress against objectives.

A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. The orientation process includes a full induction for all employees and role specific induction training. For caregivers, training and competency modules are completed in addition to enrolment into the aged care education programme.

There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. Registered nursing staff are rostered 24 hours a day, seven days a week and staffing levels meets contractual requirements.

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. Residents' files are kept in secure areas and there is no information containing personal resident information able to be viewed by other residents or members of the public.

Continuum of Service Delivery

The service has a policy for admission and entry for rest home, hospital or dementia care units. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and that the admission agreement is discussed with them. The registered nurse is responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, 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. Resident files are integrated and include notes by the GP and allied health professionals. There is an improvement required around implementing dietitian instructions for weight monitoring. The GP completes three monthly resident reviews.

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 groups. Spiritual and cultural preferences and needs are being met. Community links are maintained. There is regular entertainment and outings.

Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. The GP reviews the medication chart three monthly. There are improvements required around self-medication. Food services and all meals are provided on site and transported to each dining area for serving. Resident's individual food preferences, likes and dislikes are known. Alternative choices are offered. There are nutritional snacks available 24 hours in the special care units. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

Safe and Appropriate Environment

The facility is purpose built. All building and plant have been built to comply with legislation. The service is currently operating under a code of compliance dated 1 July 2014. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. All rooms have ensembles. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensembles. The lounge areas in each wing are spacious.

Activities can occur in any of the lounges. Furniture is arranged to ensure residents are able to move freely and safely in all units.

The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. Chemicals are stored safely throughout the facility.

The gardens and grounds are well maintained and can be accessed safely. The special care unit has safe secure outside access and spacious internal walking pathways.

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. The general practitioner (GP), resident/family/whanau and approval committee are involved in the restraint process. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and on-going. There are seven residents with restraints in use and two residents with enablers in use.

Infection Prevention and Control

The infection control team at Kiri Te Kanawa is integrated as part of the two monthly infection control/health & safety meeting. Monthly collation data is forwarded to Ryman head office for analysis and benchmarking. The infection control officer implements the surveillance, organises training and implements and reviews internal audits. The infection control policies are comprehensive and reflect best practice. Infection control (IC) training is provided at least annually to staff. There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed.

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:	Kiri Te Kanawa Retirement Village Limited		
Certificate name:	Kiri Te Kanawa Retirement Village Limited		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Certification Audit		
Premises audited:	Kiri Te Kanawa Retirement Village		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care		
Dates of audit:	Start date: 18 August 2014	End date: 19 August 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:	67
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Audit Team

Lead Auditor	XXXXXX	Hours on site	8.5	Hours off site	6
Other Auditors	XXXXX	Total hours on site	16	Total hours off site	8
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	24.5	Total audit hours off site	17	Total audit hours	41.5
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Number of residents interviewed	12	Number of staff interviewed	18	Number of managers interviewed	4
Number of residents' records reviewed	9	Number of staff records reviewed	17	Total number of managers (headcount)	4
Number of medication records reviewed	18	Total number of staff (headcount)	78	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

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	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 Monday, 29 September 2014

Executive Summary of Audit

General Overview

Ryman Kiri Te Kanawa is owned by Ryman Healthcare. The service has capacity for up to 127 residents including providing rest home level care in 30 serviced apartments. On the day of the audit there were 67 residents: 38 residents receiving rest home level care including five in serviced apartments, 26 residents receiving hospital level care and three residents in the dementia unit. One 12 room rest home wing is available for use but has not yet opened. The manager is new to the service and is currently undergoing a comprehensive orientation. He is supported by a clinical manager who has been at the service for two weeks and has six years' experience in Ryman aged care facilities. The regional manager has been overseeing the facility between managers. Families, residents and the general practitioner interviewed spoke very positively of the care provided. This audit has identified areas requiring improvement around complaint documentation, self-medication documentation and weights for one resident.

Outcome 1.1: Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and services provided, is fully available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Staff training takes place on an annual basis, reinforcing delivery of care based on the rights of the residents and their family/whanau and their freedom of choice. Care plans reflect these core values and interviews with residents and family/whanau are positive about the service understanding and implementing their values and beliefs.

There is a Maori health plan and supporting policies that acknowledge the Treaty of Waitangi. The plan identifies culturally safe practices for Maori and recognition of Maori values and beliefs. The Maori health plan identifies the importance of whanau and this is seen as a highlight of the service.

On-going staff development through education and in-service training is strongly supported and this enhances the quality and risk management programme. Training and the delivery of service, supports evidenced-based practice. There is an improvement required around complaint documentation.

Residents and family interviewed praised the care provided and Kiri Te Kanawa in general and they state that the quality has vastly improved with the employment of the new management team.

Outcome 1.2: Organisational Management

Ryman has quality and risk management systems implemented across the facilities that are monitored by head office. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards.

The service at Kiri Te Kanawa is led by a village manager who is new to the role and currently undergoing a comprehensive orientation. He has a background in senior management roles in financial services and is supported by the assistant manager who has been formally in the role since April 2014, the clinical manager who is a registered nurse and the regional manager who has extensive experience in aged care.

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A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. The orientation process includes a full induction for all employees and role specific induction training. For caregivers, training and competency modules are completed in addition to enrolment into the aged care education programme.

There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. Registered nursing staff are rostered 24 hours a day, seven days a week and staffing levels meets contractual requirements.

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. Residents' files are kept in secure areas and there is no information containing personal resident information able to be viewed by other residents or members of the public.

Outcome 1.3: Continuum of Service Delivery

The service has a policy for admission and entry for rest home, hospital or dementia care units. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and that the admission agreement is discussed with them. The registered nurse is responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, 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. Resident files are integrated and include notes by the GP and allied health professionals. There is an improvement required around implementing dietitian instructions for weight monitoring. The GP completes three monthly resident reviews.

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 groups. Spiritual and cultural preferences and needs are being met. Community links are maintained. There is regular entertainment and outings.

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Outcome 1.4: Safe and Appropriate Environment

The facility is purpose built. All building and plant have been built to comply with legislation. The service is currently operating under a code of compliance dated 1 July 2014. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. All rooms have ensuites. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. The lounge areas in each wing are spacious.

Activities can occur in any of the lounges. Furniture is arranged to ensure residents are able to move freely and safely in all units. The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. Chemicals are stored safely throughout the facility.

The gardens and grounds are well maintained and can be accessed safely. The special care unit has safe secure outside access and spacious internal walking pathways.

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. The general practitioner (GP), resident/family/whanau and approval committee are involved in the restraint process. Restraint use is discussed at RN, staff

and management meetings. There is restraint education at orientation and on-going. There are seven residents with restraints in use and two residents with enablers in use.

Outcome 3: Infection Prevention and Control

The infection control team at Kiri Te Kanawa is integrated as part of the two monthly infection control/health & safety meeting. Monthly collation data is forwarded to Ryman head office for analysis and benchmarking. The infection control officer implements the surveillance, organises training and implements and reviews internal audits. The infection control policies are comprehensive and reflect best practice. Infection control (IC) training is provided at least annually to staff. There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	47	0	3	0	0	0
Criteria	0	98	0	3	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	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 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	Four of the 17 complaints in 2014 do not have evidence of the complainant having been informed in writing of the outcome of the complaint.	Ensure the complainant is informed in writing of the outcome of each complaint.	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	One hospital resident with weight loss has been seen by the GP and referred to the dietitian. The dietitian notes request fortnightly weights. There is no evidence of fortnightly weighs implemented as per dietitian notes.	Ensure dietitian instructions followed and implemented.	60
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 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	The resident who is self-administering medicines does not have a medication chart in place or monitoring in place.	Ensure self-medication policies and procedures are followed for self-medicating residents.	30

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:

Policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and competency questionnaires. Interviews with six caregivers (one dementia, one serviced apartment, two hospital and two rest home) showed an understanding of the key principles of the code of rights. Resident rights/advocacy/complaints training was provided in April 2014.

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 information booklet/folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and, as appropriate, their legal representative. On-going opportunities occur via regular contact with family.

Advocacy pamphlets are clearly displayed on the noticeboard on each floor. Advocacy is brought to the attention of residents and families at admission and via the monthly resident meetings and the information pack.

Interviews with 12 residents (seven rest home and five hospital) all confirmed that information has been provided around advocacy.

D6, 2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, OR pamphlet, advocacy and H&D Commission.

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:

The facility provides physical, visual, auditory and personal privacy for residents. During the visit, staff demonstrated gaining permission prior to entering resident private areas. The service has a policy in place that includes that personal belongings are not used as communal property. Six caregivers interviewed described ensuring privacy by knocking before entering.

Values and beliefs information and resident preferences are gathered on admission with family involvement and is integrated with the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with six caregivers identified how they get to know resident values, beliefs and cultural differences.

Interviews with 12 residents confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with six caregivers (across am and pm shifts) described providing choice including what to wear, food choices, how often they want to shower, activities and whether they want to be involved in activities.

The serviced apartment coordinator and manager described 'aging in place' and assisting residents to stay in their serviced apartment with increased support when residents assessed as requiring rest home level.

There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years. Abuse and neglect training was last delivered in June 2014. There are two competency questions included in the induction programme around abuse and neglect which staff have completed. Staff competency questionnaires are also completed as part of the Ryman Accreditation Programme (RAP) programme; these include questions around abuse and neglect and are completed annually by staff. Discussions with 12 residents and five family members were overall positive about the care provided.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.

E4.1a Two dementia families' states that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified,

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:

There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff receive cultural training. Cultural needs and support is identified in care plans. There is an established Maori Health plan and individual care plans include the cultural needs of residents.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). D20.1i The service has developed a link with a local kaumatua and several local marae. The kaumatua meets monthly with the eight Maori residents and any Maori staff (or other staff) who choose to attend.

The policies for Māori identify the importance of whānau and six caregivers and six registered nurses (two RNs , the serviced apartment co-ordinator, the hospital co-ordinator and the rest home co-ordinator and the clinical manager), discussed the importance of family involvement. Discussion with five relatives confirm that they are regularly involved.

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:

The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans.

D3.1g The service provides a culturally appropriate service by ensuring individual needs are met including the Kaumatua meeting monthly with Maori residents and staff.

D4.1c Care plans reviewed included the resident's 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:

Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. Six registered nurses interviewed were able to describe appropriate boundaries between staff and residents and their families. Completed competence assessment to update to new scope was completed by the enrolled nurses in 2011.

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:

Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a thorough and individualised Ryman Accreditation Programme (RAP). This programme includes using some indicators from the standard on safe indicators in aged care and for rest homes/hospitals for falls rate and urinary tract infections targets. Care planning is holistic and integrated. There is a strong commitment to staff development by way of education and in-service training.

A2.2 Services are provided at Kiri Te Kanawa that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 All approved service standards are adhered to.

D17.7c There are implemented competencies for care workers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

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

Attainment and Risk: FA

Evidence:

Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise. Access to interpreter services is identified in the community. This includes language support, the DHB, Hearing Association and the Blind Foundation. As there is a multi-cultured staff and residents, caregivers described being able to interpret for some residents when needed.

A review of 17 incident forms for July 2014 show that relatives are informed of all incidents. The five relatives interviewed (two from the dementia unit, two from the hospital and one from the rest home) confirm they are kept well informed of any changes in a resident's health status.

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 Five relatives stated that they are always informed when their family members health status changes.

'D11.3 The information pack is available in large print and advised that 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. Six caregivers interviewed (one dementia, one serviced apartments, two rest home and two hospital) and six registered nurses (two registered nurses (RN)s, the serviced apartment co-ordinator, the hospital co-ordinator and the rest home co-ordinator and the clinical manager), 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 in one of two dementia care resident files.

D3.1.d: Discussion with five family members interviewed (one rest home, two dementia, two hospital) 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:

Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file.

D4.1d; Discussion with five relatives (two from the dementia unit, two from the hospital and one from the rest home) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1d; Discussion with five family identified that the service provides opportunities for the family/EPOA to be involved in decisions.

ARC D4.1e: The resident file includes information on resident's 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:

The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations.

D3.1h: Discussion with five families confirms that they are encouraged to be involved with the service and care.

D3.1.e D discussion with six caregivers (one dementia, one serviced apartment, two hospital and two rest home), two RNs , the serviced apartment co-ordinator, the hospital co-ordinator and the rest home co-ordinator, the clinical manager, and five relatives confirms that they are supported and encouraged to remain involved in the community and external groups such as café and shopping visits.

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: PA Low

Evidence:

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on VCare. Complaints and verbal complaints reviewed for 2014 to date were tracked. There have been a total of 17 complaints during this time, 14 of which related to resident care. All complaints have been acknowledged within the required timeframe and 13 have evidence of the complainant being informed of the outcome of the investigation. Improvement is required. For seven complaints quality improvement plans have been developed and implemented to address issues. As a result of the high number of care complaints a number of initiatives have been introduced. These include tiers of caregivers, extra cleaning staff, the appointment of a unit manager for each area, the development of a senior caregiver's team and a weekly meeting between management and the senior caregivers. The monthly staff meeting identified discussion of complaints and opportunities for improvement in service delivery.

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

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: PA Low

Evidence:

Complaints are documented on VCare. Complaints and verbal complaints reviewed for 2014 to date were tracked. There have been a total of 17 complaints during this time, 14 of which related to resident care. All complaints have been acknowledged within the required timeframe and 13 have evidence of the complainant being informed of the outcome of the investigation. For seven complaints quality improvement plans have been developed and implemented to address issues. As a result of the high number of care complaints a number of initiatives have been introduced. These include tiers of caregivers, extra cleaning staff, the appointment of a unit manager for each area, the development of a senior caregiver's team and a weekly meeting between management and the senior caregivers.

Finding:

Four of the 17 complaints in 2014 do not have evidence of the complainant having been informed in writing of the outcome of the complaint.

Corrective Action:

Ensure the complainant is informed in writing of the outcome of each complaint.

Timeframe (days): 90 (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:

Kiri Te Kanawa is a modern facility that is part of a wider village. The service has capacity for up to 97 residents plus 30 rest home level residents in serviced apartments. On the day of the audit there were 97 residents: 33 residents receiving rest home level care including 1five in serviced apartments, 26 residents receiving hospital level care and three residents in the dementia unit. One 12 room rest home wing is available for use but has not yet opened. Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. To monitor organisation performance, the manager reports weekly to head office and RAP committee meetings occur monthly. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme (RAP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation and there are clear guidelines and templates for reporting.

The manager is new to the service and is currently undergoing a comprehensive orientation. He is supported by a clinical manager who has been at the service for two weeks and has six years' experience in Ryman aged care facilities. The regional manager has been overseeing the facility between managers.

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:

During a temporary absence, the clinical manager undertakes the role of village manager.

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that 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:

Kiri Te Kanawa continues to implement a comprehensive quality and risk management system that is directed by head office. The RAP includes a schedule across the year for the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Kiri Te Kanawa at the onsite monthly RAP staff meetings and weekly management meetings.

Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with six caregivers and review of the staff meeting minutes demonstrate their involvement in quality and risk activities.

Resident meetings are held on a monthly basis. Minutes are maintained. Annual resident and relative surveys are completed. The relative survey May 2014 identified an improvement in satisfaction from the October 2013 survey after which quality improvement projects were initiated around the food and laundry services.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. The RAP programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar (sited). There are adequate clinical policies and procedures to rest home level care. The two monthly journal club (attended by all three registered nurses) is directed by head office, reviews the latest clinical practice articles.

A quality assistant checklist and RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. a) There is monthly accident/incident reports completed that break down the data collected across the facility. Reports are provided from the village manager to head office that includes a collation of staff incidents/accidents and resident incidents/accidents. Kiri Te Kanawa also provides a six monthly comparative summary report that includes recommendations for residents and staff and training conducted. These are also compared with the previous six month. b) The monthly manager's report includes complaints/concerns/compliments. Quality improvement plans are initiated where required (link 1.1.13.1). c) All infections are documented in a monthly summary report and discussed in the bi-monthly health and safety / IC meeting with a report forwarded to the monthly RAP committee meeting. Monthly reports to head office include a monthly summary of infections, statistics, clinical summaries and education. d) Health and safety is addressed through the two monthly health and safety, e) the restraint approval group meets six monthly.

Monthly benchmarking occurs throughout the Ryman group.

The service collects data to support the implementation of corrective action plans.

The internal auditing annual schedule is implemented as per schedule. There has been a recent change in who completes each audit with the creation of a clinical auditor position. An organisational spot audit by the clinical auditor and a support auditor was completed in June 2014 which includes (but not limited to) review of clinical documentation and practise. The report was sighted on line. Other audits are completed between the village and clinical managers. Meetings are minuted with reference to location of details of actions required and resolved for areas identified for improvement and quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement.

D19.3 Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. A health and safety officer is appointed and interview with six caregivers that included the representative on the committee were able to outline risk management and hazard control activities and requirements. Risk management, hazard control and emergency policies and procedures are in place. The organisation's benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Manual handling training is provided to staff.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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 service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. A six monthly comparative analysis is completed of incidents for internal benchmarking. In addition, each facility receives an analysis of the last six monthly period from which to identify trends and improvements. These reports were sighted during the audit.

Minutes of the monthly RAP committee meetings, two monthly health and safety meetings, which include infection control and monthly full facility meetings reflect a discussion of incidents/accidents. Monthly analysis of incidents includes comparison with previous month.

An incident reporting severity matrix has been developed by head office and is implemented at Kiri Te Kanawa.

Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Incidents details are entered into V-care as the investigations are completed and a report generated at the end of the month. Incident reports are then filed in the resident or staff members file. August reports to date were 17 and analysis was underway. Seventeen incident reports were sampled. All forms were fully completed and included registered nurse assessment. The resident with frequent falls had assessment and short term care plan developed.

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.

D19.3c 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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A register of registered nurse practising certificates is maintained within the facility. The current general practitioners' registration is printed from the professional body's website. Allied health practitioners are asked to provide evidence of registration as appropriate (for example, physiotherapist and podiatrist) and a copy is retained by the facility.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (three caregivers, the clinical manager, two unit coordinators, one other registered nurse, the kitchen manager and the diversional therapist). All included their relevant induction books, referee checks and training and development records.

Kiri Te Kanawa has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as (but not limited to) caregiver, senior caregiver, registered nurse, H&S rep, clinical manager and gardener. The orientation/induction training for caregivers, on completion, provides them with a level two national certificate in support of the older person. This was a quality initiative by Ryman in 2010 and monitored by the organisation. There is a specific employees' induction manual. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent.

The orientation process includes; full induction with all employees and caregiver modules followed by enrolment into the ACE programme to achieve ACE core, ACE advanced and/or ACE dementia, as appropriate, if not achieved prior to employment.

There is an implemented education plan 2014. The annual training programme well exceeds eight hours annually. Staff education and training includes the aged care education (ACE) programme for caregivers. On-going training via in-service programme to meet MOH guidelines and any ad hoc training specific to the Village or resident needs. Attendance encouraged at full facility meetings to ensure participation in the Ryman Accreditation Programme. Yearly formal performance review for reflective practice and setting goals including up skilling or other training or qualification goals. Caregivers complete yearly comprehension surveys.

Registered nurses are supported to maintain their professional competency and there is also a foreign trained nurse development programme. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. Interviews with two RNs, the serviced apartment co-ordinator, the hospital co-ordinator and the rest home co-ordinator and the clinical manager identified that participation in the RN Journal Club is used to advise current practice and provide clinical updates and guidance. Yearly formal performance review specific to RNs for reflective practice and setting goals including up skilling or other training or qualification goals.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medications, restraint and syringe drivers.

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

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are four caregivers who work in the dementia unit and all have completed the required dementia standards.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a policy called determining staffing levels and skills mix which is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.

Staff on the floor on the days of the audit are visible and are attending to call bells in a timely manner as confirmed by all residents interviewed (14).

Interviews with six caregivers (one from the dementia unit, one from the serviced apartments, two from the hospital and two from the rest home) state that overall the staffing levels are satisfactory and that the management team provides good support. The caregivers interviewed state that the registered nurses and enrolled nurses are responsive on the whole and they can access the clinical manager if needed. The registered nurses and enrolled nurses state that they can access the hospital coordinator (newly appointed) and the clinical manager for support. Residents interviewed (five hospital, seven rest home) and relatives interviewed (two hospital, two dementia care and one rest home) report there is adequate staff numbers.

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.)*

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: FA

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 care plan is also developed in this time.

Policies outline security of records. Files are kept in a secure cupboards behind the nurses' station in the nurses' office in all areas. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.

D7.1 entries are legible, dates and signed by the relevant caregiver or RN including designation.

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: 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 1.2.9.10 (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 clinical manager (CM) 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 the unit co-ordinators/registered nurses of the pending admission and specific needs to be met. Information gathered at admission is retained in resident's records.

Seven rest home residents and five hospital residents interviewed confirmed they received information prior to admission and discussed the admission process with the clinical manager. Relatives (two hospital, one rest home and two dementia) interviewed stated they received sufficient admission information and had the opportunity to discuss the admission agreement with management.

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 sampled are signed prior to or on admission.

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 were reviewed and include 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 and inform them 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. Declining entry would occur if there are no beds available or the service is unable to provide the assessed level of care.

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. Two registered nurses (RN) and three unit co-ordinators (hospital, rest home and serviced apartments) know the timeframes for the development and reviews of care plans and files. Clinical staff have attended in-service and refreshers on clinical care.

D16.2, 3, 4; An initial assessment and initial care plan is completed within the required timeframes. The long term care plan is reviewed by the registered nurses and amended when current health changes. Four rest home (including one resident in the serviced apartment), three hospital and two dementia residents' files are reviewed. All long term files identified the initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe.

D16.5e; Medical assessments were documented in all nine long term resident files within 48 hours of admission.

Three monthly medical reviews were documented in nine of nine permanent resident files by 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 is noted occurring in residents with acute conditions and those requiring palliative care. The GP (interviewed) visits twice a week and as required. The GP is available until 10pm and the emergency department after 10pm. Fax and mobile phone is the main form of communication. The GP states the RN clinical assessments are well documented and communicated. The GP completes a multidisciplinary report form. The GP states the palliative care team are very supportive.

Activity assessments and activities care plans have been completed by the activity co-ordinators.

A physiotherapist is contracted to the service for six hours daily. The physiotherapist completes initial physiotherapy assessments; post falls assessments and follows up any referrals from the units. There is a physiotherapist aid employed for 15 hours a week to implement exercise programmes and follow-up physiotherapy instructions. The podiatrist visits regularly. A dietitian is available by referral.

Six caregivers interviewed (one dementia, two rest home, one serviced apartments, two hospital) and two RNs who work across morning shifts could describe a verbal handover and written handover book which details any resident concerns, incidents, infections and any other significant concerns.

Caregivers write progress notes on every shift. RN's write progress notes at least weekly and for any significant event.

Tracer methodology; Hospital Tracer

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 – Dementia care 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 to assess (if applicable) level of risk and required support for residents including (but not limited to); a) Waterlow pressure area risk assessment, b) skin integrity, c) continence, d) coombes falls risk, e) dietary profile f) pain/Abbey scale assessment g) physiotherapy assessment. h) Behavioural assessment i) nutritional needs screening tool j) wound assessment k) restraint assessment. Assessments are reviewed when there is a change to condition or at least six monthly. A full nursing assessment is completed on admission.

ARC E4.2; Two resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4, 2a Challenging behaviours assessments are completed in two of two special care unit resident files.

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. Interview with two registered nurses and four unit co-ordinators verified involvement of families in the care planning process. Families/residents sign an acknowledgment of involvement in care plan development and reviews. Five relatives interviewed (one rest home, two dementia and two hospital) confirmed they are involved in the care planning process.

Each area of the care plan includes: problems/needs, objectives and interventions. All resident files sampled have current long term care plans that reflect the resident's current needs.

Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as physiotherapist, podiatrist, dietitians, occupational therapist and mental health services. Allied health professionals involved in the residents care is linked to the long term care plan.

The activities co-ordinators develop individual activity care plans.

Physiotherapy progress notes, podiatry, medical and other allied health visits are documented in the integrated resident file.

E4.3 Two of two special care resident files included a behaviour assessment and behaviour nursing care plan identifying current abilities, level of independence and identified needs.

D16.3k, Short term care plans are in use for acute events or changes in health status. Examples sighted are as follows: wound infection, urinary tract infection (UTI), skin tear, pain, bruise, chest infection and cellulitis.

D16.3f; Nine of nine resident files reviewed identified that family were involved. Relatives interviewed 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:

Nine resident files are reviewed (four rest home, three hospital, two special care unit). Residents interviewed (five hospital, seven rest home) report their needs are being appropriately met. Relatives interviewed (two hospital, two dementia care and one rest home) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. Discussion with family and notifications are identified in the progress notes with a "relative contact" stamp.

D18.3 and 4 Dressing supplies are available and a treatment room is well stocked with supplies. Wound assessment and wound management and evaluation plans are in place for five wounds, three skin tears and four pressure areas (two sacral and two heel, all grade 1) in the hospital unit. There are six wounds three skin tears and one pressure area of heel in the rest home. There are no wounds in the dementia care unit. Evaluations, wound assessments and pain level is carried out at each dressing change and signed by the RN. Wound mapping charts and photographs are evident as required. There is evidence of wound care specialist notes in the progress notes for resident with chronic arterial ulcers. Chronic wounds are linked to the long term care plans (sighted). Short term care plans are completed for skin tears.

Continence products are available and resident files include a three day diary continence assessment to identify urinary incontinence, bowel management, and continence products for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the two RN's interviewed.

Weigh chair scales (calibrated September 2013) are used to weigh residents monthly. At risk residents and those with unintentional weight loss are monitored more frequently. Weight loss short term care plans in place include interventions listed as fortnightly weigh, drink supplements (smoothies, complan), food and fluid monitoring, frequent in-between snacks, high protein diet, GP and kitchen notification and dietitian referral. The dietitian writes up diet plans and instructions for residents in the integrated file. There is an improvement around implementing dietitian instructions.

Challenging behaviour assessments are completed on admission for special care unit residents. A behaviour nursing care plan is developed. Altered behaviour is monitored on behaviour monitoring charts. Light sensors in rooms and bed pad sensors are used in the dementia unit to alert staff of the

resident getting up.

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:

Weigh chair scales (calibrated September 2013) are used to weigh residents monthly. At risk residents and those with unintentional weight loss are monitored more frequently. Weight loss short term care plans in place include interventions listed as fortnightly weigh, drink supplements (smoothies, complan), food and fluid monitoring, frequent in-between snacks, high protein diet, GP and kitchen notification and dietitian referral. The dietitian writes up diet plans and instructions for residents in the integrated file.

Finding:

One hospital resident with weight loss has been seen by the GP and referred to the dietitian. The dietitian notes request fortnightly weights. There is no evidence of fortnightly weighs implemented as per dietitian notes.

Corrective Action:

Ensure dietitian instructions followed and implemented.

Timeframe (days): 60 (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 is a registered diversional therapist (DT) and two activity co-ordinators that implement activity programmes across the rest home, hospital, and special care unit and serviced apartments Monday to Friday with organized weekend activities. All resident activities including the weekly special activities have

recently been integrated into one bright and colourful programme for each area and residents receive a copy in their rooms. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.

The DT is based in the hospital area and spends 1.5 hours in the special care unit each day. Caregivers provide activities and one on one time for residents in the special care unit. There is one activity co-ordinator for the rest home and one for the serviced apartments. Rest home residents in the serviced apartments choose to attend the serviced apartment activity programme which includes (but not limited to) Triple A exercises, entertainment, outings, arts, crafts, movies, quizzes, bowls, cards, theme events and happy hours.

Special care unit activities are focused around individual activities and sensory stimulation and reminiscing. Music is enjoyed and residents are supervised to attend entertainment, drives and outings with the hospital residents. Residents are taken for supervised walks, participate in crafts/arts, ball and board games, triple A exercises, storytelling and happy hours

Hospital residents enjoy regular entertainment, crafts, reminiscence and storytelling, newspaper reading, balls games; Triple A exercises, bingo, board games and quizzes and walks. One on one time is spent with residents (massage, pampering, wheelchair walks) who are unable to participate in group activities or who choose not to.

Rest home activities include (but not limited to); newspaper reading and discussion, bingo, word games, movies, cards, beauty care, bowls, arts/crafts and movies.

There are a variety of entertainers and community visitors to the facility such as musical entertainers, visiting pets, Hospice choir, Karakia/Waiata, senior citizens and church visitors. There are regular church services. There is a library service within the serviced apartments with large print books available.

Outings (scenic drives, picnics, shopping and café visits) are designed to meet the consumer group and individual needs. The activity team all have current first aid certificates and have completed defensive driving courses

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

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed within 21 days 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 care plan. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. The activity care plan is reviewed six weeks post admission and six monthly thereafter with the RN, GP, and family/resident. The activity team liaise closely with the carers.

The programme is evaluated and can be individually tailored according to resident's needs. Bi-monthly resident meetings are held which also includes discussion and feedback on the activity programme. Guest speakers are invited. Feedback on the activity programme is also received from internal audits and resident surveys.

Hospital and rest home residents and 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 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 special care unit. Short term care plans are evaluated regularly and either resolved or added to the long term care plan if an on-going problem. The multidisciplinary team (MDT) include the clinical manager, RN, Physiotherapist, GP, activity team, resident/family, physiotherapist and other allied health professionals as appropriate. Family are invited to attend review meetings by letter (correspondence noted in files sighted). Any changes to the long term care plan are dated and signed by the RN. The GP reviews the resident medications at least three monthly. Activity care plans are reviewed at the MDT reviews.

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

ARC: 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 1.3.9: 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. Two RN's and four unit co-ordinators interviewed state they initiate referrals to nurse specialist services. The GP is notified of any nurse specialist referrals. The GP initiates any specialist or consultant referrals. Referrals and options for care are discussed with the family as evidenced in medical notes. Referrals sighted on the resident files sampled are as follows: podiatry, physiotherapy, dietitian, dermatology, women's health clinic, occupational therapist and radiology.

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.
D 20.1 Discussions with two 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.

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 service 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 hospital file reviewed of a resident transferred acutely to hospital identified that a transfer form was completed and family notified. A discharge summary and nursing discharge summary is evident in the residents file when transferred back to the facility. Relatives 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 Low

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 and PRN medications. The medications are delivered monthly and checked in by the RN on duty and any discrepancies are fed back to the supplying pharmacy. Blister packs sighted had RN signature on the back to verify they had been checked. The returns are stored safely in the medication room until picked up by the supplying pharmacy. Medications are stored in locked trolleys within the treatment room. All eye drops in use are dated on opening. There are no controlled drug stocks. All controlled drugs in the safe are prescribed for individual residents. There are weekly controlled drug checks. The special care unit and serviced apartments use the rest home controlled drugs safe and medication fridge if required. Medication fridge's are monitored weekly (records sighted). The oxygen, suction and emergency trolley are checked weekly (checklist sighted). The oxygen concentrator has been checked August 2014. The first aid kit is checked monthly.

The RNs administered medication in the hospital, rest home and special care unit during the day. Senior caregivers administer afternoon shift medications in the rest home and to rest home residents in serviced apartments. All senior caregivers/RNs /enrolled nurse (EN)'s administering medication complete a medication orientation package and annual medication and insulin competencies. Annual education is attended. RNs have not completed syringe driver training. There is support from hospice nurses and specialists should a syringe driver be required. Standing orders are current. PRN medications have the time of administration on the signing sheet. Controlled drugs and warfarin doses are signed by two persons. There are no gaps on the medication signing sheets. There is one resident in the serviced apartment that is self-administering medications. There is an improvement required around self-administration procedures.

Eighteen medication charts sampled (two serviced apartments, six rest home, seven hospital, three dementia) record prescribed medications by residents' general practitioner, including PRN and short course medications. All medication charts have photo identification and allergies/adverse reactions documented. There are special instructions for the crushing and administration of medications.

D16.5.e.i.2; Eighteen medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: 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 1.3.12.3 (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: PA Low

Evidence:

There is one resident in the serviced apartment that is self-medicating.

Finding:

The resident who is self-administering medicines does not have a medication chart in place or monitoring in place.

Corrective Action:

Ensure self-medication policies and procedures are followed for self-medicating residents.

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

Criterion 1.3.12.6 (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/food supervisor on Monday to Friday 8am-5pm and a weekend cook. They are supported by a cook assistant and morning and afternoon kitchen assistant. All cooking and baking is done on site. The four weekly summer and winter menu is designed and reviewed by a Registered Dietitian at an organisational level. Food is delivered in hot boxes to each of the unit kitchenettes and served by caregivers from the bain marie. Each kitchenette has a fridge and microwave. The chef receives a resident dietary requirement for each new admission and changes to resident's dietary needs are communicated to the kitchen. Special diets and requests are labelled ready for serving. Special diets accommodated are; gluten free, diabetic desserts, vegetarian, acid free, diary free and resident likes/dislikes which are known by kitchen staff. There are lip plates and special utensils available to help

promote independence with meals. The chef is able to describe dietary requirements for resident with weight loss including high protein drinks and sandwiches, smoothies, complan and use of milk powder. "Food on the run" platters are delivered to the units daily.

Hot food temperatures are monitored twice daily. Fridges and freezers temperatures are recorded weekly. There are visual temperature displays on the fridges and freezers. Facility fridges are monitored weekly. All perishable goods in the fridges and chillers are dated. The service has a large workable kitchen that has a separate dishwashing area. All equipment is serviced as per the company schedule. The dishwasher is serviced and monitored by the chemical provider. All chemicals are stored safely. There are safety data sheets available.

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.

Feedback on the service is received from resident and staff meetings, surveys and audits. The chef attends monthly management meetings.

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

D19.2 The head chef hold a City Guild qualifications. All kitchen staff have been trained in safe food handling and chemical safety.

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. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Staff are observed wearing appropriate personal protective clothing while carrying out their duties. Chemicals are stored safely throughout the facility. Chemical bottles are labelled correctly with manufacturer labels. Safety data sheets and products charts are available. Relevant staff have attended chemical safety training August 2014.

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 currently operates under a code of compliance dated 1 July 2014. Monthly compliance checks are carried out by the maintenance person and fire protection service (sighted). There is a full time (and on call) maintenance person to carry out building maintenance on request and planned maintenance as scheduled. The maintenance person carries out day to day maintenance repairs and requests logged in the log book. Preferred contractors are available 24/7. All clinical equipment has been tested for function and calibrated as required September 2013. There are maintenance policies and procedures in place including electrical checks (completed August 2014) and a preventative maintenance schedule. Rooms are refurbished as they become vacant. Lights in communal areas are currently being replaced. Hot water temperatures are monitored three monthly. The maintenance person is the health and safety trainer. Health and safety committee meetings and general manager meetings include maintenance and preventative maintenance.

Residents have access to a library, shop, hairdresser and activity rooms within the facility.

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

There are outside areas with shade and seating that is observed to be well maintained. The residents have easy access to internal courtyards.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities. The special care unit has its own open plan lounge and dining area.
ARC D15.3; The following equipment is available, pressure relieving mattresses and cushions, shower chairs, chair scales (calibrated September 2013), sensor mats, sling and standing hoists (checked September 2013), electric beds, ultra-low beds, transferring and mobility aids. Interviews with six caregivers and two RN's working across all the units confirmed there was adequate equipment to deliver safe and timely care as per the resident care plans.
E3.3e: There are quiet, low stimulus areas that provide privacy when required. There are smaller quiet rooms for individual activity or visitor use.
E3.4.c; There is a safe and secure outside area that is easy to accessible with shaded seating areas.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

All resident rooms have ensuites. The ensuite floors are safe and easy clean vinyl surfaces. Handrails are appropriately placed in the toilet shower areas. There is a call bell system within easy reach. Communal toilets (clearly identified) are located near the lounges. .

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 and transferring equipment can be managed in ensuites. Bedrooms are personalized.

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 unit has open plan lounges and dining areas. There are also a family rooms and small lounges available. The communal lounge/dining room in the serviced apartments is spacious and allows for a number of different activities. There is a separate dining area in the large open plan living area in the secure unit. There are kitchenettes in each unit. Activities take place in a number of areas within the facility. Residents are observed as freely access the communal areas with the use of mobility aids

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. There are internal and external walking pathways.

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. The service employ dedicated cleaning staff that also complete laundry duties. The service has a secure area for the storage of cleaning chemicals on each floor. Laundry chemicals are within a closed system to the washing machines. Material safety data sheets are displayed in the cleaning cupboards. Cleaner's trolleys are well equipped. The laundry and cleaning areas have hand-washing facilities. Cleaning schedules are maintained. There are adequate linen supplies sighted. Staff interviewed are knowledgeable in the use of equipment and infection control practices. Staff have attended chemical safety, level 4 cleaning certificate and other relevant education as offered.

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. Regular fire drills are completed. Emergencies, first aid and CPR is included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Last fire drill occurred on 14 May 2014.

The fire service approved the evacuation plan on 16 April 2012. 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. There is water storage available. 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 (this includes serviced apartment rooms).

In the dementia unit 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 facility 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. There is also a certain call sound. When a staff member is in a resident room a green light shines above the resident's door. This allows for staff to know where other staff are. If the staff member with a resident rings the bell for another staff member assist, this ring is different and allows for staff to alert other staff for assistance without leaving the resident unattended.

The serviced apartments also include call bells in resident rooms and in 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.

The entire facility is secured at night. The service utilises security cameras and an intercom system. There is cameras in the hallways to increase supervision of residents. Visitor's book and resident sign out book available. The Ryman group has an adequate security checks policy and procedure.

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

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. The resident rooms have individual skope heaters. All rooms have external windows with plenty of natural sunlight. Air conditioning units are in the main corridors.

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 seven residents who have been assessed as requiring the use of a restraint (bedrails), one resident with a chair brief and two resident with enablers (bedrails). All residents are hospital level. A monthly restraint and enabler register is maintained. There are restraint monitoring guidelines in place.

Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the consent, assessment and restraint approval and review process. A registered nurse is the restraint officer. There is a job description defines the role and responsibilities. Types of restraint have been approved for use by the approval committee (GP, activity co-ordinator and care staff). The service is able to evidence a successful trial of removal of restraint.

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 overall responsibility for RN restraint officer is included in the job description. The approved restraints (bedrails, lap belts and chair brief) are documented in the restraint policy. The approval committee approve restraint use and types of restraint.

Restraint and consent is in consultation/partnership with the resident (as appropriate) or whanau, the restraint officer, 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 such as ultra-low beds and mattress on the floor, activities. 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 officer 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 by the approval committee. 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 one hospital resident with the use of two restraints identified observations and monitoring occurring within the prescribed timeframes documented on individual residents' restraint assessment. The long term care plan (under safety/risk) includes the use of restraint/enablers, frequency of monitoring and required documentation. Risks known to be associated with the use of restraints/enablers are reflected in the care plan.

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 complete restraint competencies.

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. One resident file with the use of two restraints (bedrails and chair brief) is reviewed and evidenced a restraint risk assessment, consent form and three monthly reviews for each restraint.

The file reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed by the Restraint officer and approval 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:

Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Only approved restraints are used. The service completes assessments at admission and risks are included in the care plan interventions. These are undertaken by suitably qualified and skilled staff in discussion with the family/whanau. Care plans include a full description of needs and support and are reviewed at least six monthly evaluation. All episodes of restraint is monitored.

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.

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

<p>Attainment and Risk: FA</p> <p>Evidence:</p> <p>Finding:</p>

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 officer and restraint approval committee.

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 three 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 (RN) 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 (rest home and hospital unit co-ordinator and village manager) 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 sent 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.

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 rest home and hospital unit co-ordinators. An RN is taking on the role of IC officer to cover parental leave. 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. New or reviewed policies are discussed at the full facility RAP meetings. 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 has completed on-line learning. There is annual training (including Bug Control) scheduled in October/November that the incoming IC officer (RN) to cover for parental leave will attend. The induction package includes specific training around hand washing and standard precautions. 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 and short term care plans 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 (V-care) and reported to the combined infection control and health and safety meetings. Staff are informed through the variety of meetings held at the facility including weekly RN meetings. 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. Benchmarking occurs against other Ryman facilities. 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.)*