

Ryman Napier Limited

CURRENT STATUS: 23-Jul-13

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 & NZS8134.3:2008 on the audit date(s) specified.

GENERAL OVERVIEW

Princess Alexandra Retirement Village is a modern facility that is part of a wider village. The service provides care across three service levels (rest home, hospital-medical/geriatric and dementia-level care) for up to 138 residents. The care centre includes 84 hospital/rest home beds on the ground floor with a 24 bed dementia unit. There are potentially 30 serviced apartments able to be used to provide for rest home care included in the total number of beds available. The current occupancy on the days of the audit is 36 hospital, 48 rest home including six in the serviced apartments, and 24 dementia unit residents (total 108 residents).

The facility manager, a registered nurse (RN) commenced employment with Ryman at the Princess Alexandra facility in 2009. Previous experience includes general manager, and marketing roles. She is supported by an assistant manager (enrolled nurse), hospital coordinator (RN) and a rest home coordinator (RN) and a serviced apartment coordinator (enrolled nurse) who also supports the independent apartments. The team leader in the dementia unit is an enrolled nurse.

Ryman Healthcare has an organisational total quality management plan and key operations quality initiatives that are implemented at Princess Alexandra. The service is commended for achieving a continued improvement rating around the activities programme. This audit identified three improvements required around aspects of care planning and medication management.

AUDIT SUMMARY AS AT 23-JUL-13

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

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

Consumer Rights	Day of Audit 23-Jul-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained

Organisational Management	Day of Audit 23-Jul-13	Assessment
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

Continuum of Service Delivery	Day of Audit 23-Jul-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Safe and Appropriate Environment	Day of Audit 23-Jul-13	Assessment
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained

Restraint Minimisation and Safe Practice	Day of Audit 23-Jul-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained

Infection Prevention and Control	Day of Audit 23-Jul-13	Assessment
Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained

AUDIT RESULTS AS AT 23-JUL-13

Consumer Rights

Policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome information booklet/folder includes information about the Code. Residents and families are informed regarding the Code and employees receive on-going training about the Code.

Princess Alexandra Retirement Village provides physical, visual, auditory and personal privacy for residents. Values and beliefs information and resident preferences are gathered on admission with family involvement. This information is integrated with the residents' care plans.

There is an established Maori Health Plan that is completed for Maori residents. Individual care plans include any cultural needs identified by residents and/or their family. Discussions with relatives confirm that families are regularly involved.

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 families including if an incident or care/medical issue arises.

The service has visiting arrangements that are suitable to residents and family. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution.

Organisational Management

Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely 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 village manager at Princess Alexandra Retirement Village has been in her role at the facility since 2009.

Princess Alexandra Retirement Village has a well-established and comprehensive quality and risk management system and quality and risk performance is reported across the facility meetings and to the organisation's management team. Internal audits are completed as designated by the programme schedule with evidence of corrective action plans completed with resolution documented. Clinical and non-clinical indicators are monitored and facility performance is measured against these.

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 strong commitment to staff development by way of education and in-service training. There are experienced registered nurses and enrolled nurses who provide leadership. Registered nurses are supported to maintain their professional competency. Employee training records are maintained.

There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. Registered nursing staff are staffed 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 well-developed information pack available for residents/families/whānau at entry. The registered nurses are responsible for undertaking the assessments on admission. Communication with family is recorded. The long term care plan includes nursing diagnosis, objectives of nursing care, setting goals, and details of implementation. Short term care plans are well utilised for changes in health status, such as wound care and infections. Nursing care plans reviewed were individualised, accurate and up to date, However there is

one improvement required around aspects of care planning documentation. The care being provided is consistent with the needs of residents and reviewed at least six monthly.

Activities programmes are planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. The activity team described the 'Spice of Life' programme, a resident focused programme to enable the village to support residents achieving their own, personalised goals. A continuous improvement has been attained around the activity/recreational programme.

The medication management system includes a policy that follows recognised standards and guidelines for safe medicine practice. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents' general practitioner at least three monthly. There is an improvement required around ensuring that medications are signed for on administration and as prescribed.

The service has a large workable kitchen with a menu is designed and reviewed by a registered Dietitian, staff at the facility have completed food safety training. Two monthly resident meetings are held and meals are discussed. Residents stated the food was satisfactory. Regular audits of the kitchen fridge/freezer temperatures and food temperatures are undertaken and documented.

Safe and Appropriate Environment

All building and plant have been built to comply to legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. There are adequate numbers of toilets and showers across the facility with access to a hand basin and paper towels. All rooms in the hospital/rest home have ensuite. There are no rooms with ensuite facilities in the dementia unit. 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 en-suites. The lounge areas are spacious in all units and quiet lounges are also available. Activities can occur in any of the lounges. Furniture is arranged to ensure residents are able to move freely and safely in all areas.

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.

The Ryman group emergency and disaster manual deals with emergencies and disasters, essential locations, internal emergencies and external emergencies. Regular fire drills are completed. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years. 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. A specialised call bell system in the dementia unit is connected to a bed sensor and lights, reducing the risk of falls.

Restraint Minimisation and Safe Practice

A comprehensive restraint minimisation and safe practice programme is in place. The restraint coordinator is an experienced registered nurse. Processes are in place to ensure restraint is used only as a last resort. Consent processes are in place, including the resident, family, nursing staff and the medical practitioner.

There are seven residents using an enabler and eleven residents using restraint. Approved restraints include bedrails and chair supports/lap belts. Strategies are in place to minimise the use of restraint including sensor mats, electric beds, mobility aids and an electrical monitoring system that alarms staff when residents get out of their bed and turns lights on in the resident's room.

Infection Prevention and Control

The infection control coordinator implements the surveillance, organises training and implements and reviews internal audits. Monthly collation tables are forwarded to Ryman head office for analysis and benchmarking. 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 six monthly comparative summary is completed.

Princess Alexandra Retirement Village

Ryman Napier Limited

Certification audit - Audit Report

Audit Date: 23-Jul-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	RN, auditor certificate	19.30	8.00	22-Jul-13 to 23-Jul-13
Auditor 1	XXXXXXXX	MBA MN B Ed Adv Dip Child and Family Dip Tchg Lead auditor	9.00	6.00	23-Jul-13 (flight cancelled due to fog)
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			2.00	

Total Audit Hours on site	28.30	Total Audit Hours off site <i>(system generated)</i>	16.00	Total Audit Hours	44.30
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Staff Records Reviewed	11 of 140	Client Records Reviewed <i>(numeric)</i>	11 of 108	Number of Client Records Reviewed using Tracer Methodology	3 of 11
Staff Interviewed	20 of 140	Management Interviewed <i>(numeric)</i>	6 of 6	Relatives Interviewed <i>(numeric)</i>	7
Consumers Interviewed	11 of 108	Number of Medication Records Reviewed	22 of 108	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	1

Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) 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 Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 25 day of August 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit:

The audit summary has been developed in consultation with the provider:

Electronic Sign Off from a DAA delegated authority (*click here*):

Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Princess Alexandra Retirement Village	138	108	60	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

Princess Alexandra Retirement Village is a modern facility that is part of a wider village. The service provides care across three service levels (rest home, hospital -medical/geriatric and dementia-level care) for up to 138 residents. The care centre includes 84 hospital/rest home beds on the ground floor with a 24 bed dementia unit. There are potentially 30 serviced apartments able to be used to provide for rest home care included in the total number of beds available. The current occupancy on the days of the audit is 36 hospital, 48 rest home including six in the serviced apartments, and 24 dementia unit residents (total 108 residents).

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2 Restraint Minimisation and Safe Practice

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3. Infection Prevention and Control

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Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	FA	0	1	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	FA	0	2	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	FA	0	4	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	FA	0	3	0	0	0	7
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	FA	0	1	0	0	0	2
Standard 1.1.7	Discrimination	FA	0	1	0	0	0	5
Standard 1.1.8	Good practice	FA	0	1	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	FA	0	3	0	0	0	9
Standard 1.1.11	Advocacy and support	FA	0	1	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	FA	0	2	0	0	0	2
Standard 1.1.13	Complaints management	FA	0	2	0	0	0	3

Consumer Rights Standards (of 12):	N/A:0	CI:0	FA: 12	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:0	FA:23	PA:0	UA:0	NA: 0			

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	2	0	0	0	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	FA	0	8	0	0	0	9
Standard 1.2.4	Adverse event reporting	FA	0	2	0	0	0	4
Standard 1.2.7	Human resource management	FA	0	4	0	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	FA	0	4	0	0	0	10

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 7	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:0	FA:22	PA:0	UA:0	NA: 0		

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	FA	0	1	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	FA	0	1	0	0	0	2
Standard 1.3.3	Service provision requirements	FA	0	3	0	0	0	6
Standard 1.3.4	Assessment	PA Low	0	0	1	0	0	5
Standard 1.3.5	Planning	FA	0	2	0	0	0	5
Standard 1.3.6	Service delivery / interventions	FA	0	1	0	0	0	5
Standard 1.3.7	Planned activities	CI	1	0	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	2
Standard 1.3.12	Medicine management	PA Moderate	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:1	FA: 9	PA Neg: 0	PA Low: 1	PA Mod: 1	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:1	FA:18	PA:2	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.4.1	Management of waste and hazardous substances	FA	0	2	0	0	0	6
Standard 1.4.2	Facility specifications	FA	0	3	0	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities	FA	0	1	0	0	0	5
Standard 1.4.4	Personal space/bed areas	FA	0	1	0	0	0	2
Standard 1.4.5	Communal areas for entertainment, recreation, and dining	FA	0	1	0	0	0	3
Standard 1.4.6	Cleaning and laundry services	FA	0	2	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems	FA	0	5	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	FA	0	2	0	0	0	3

Safe and Appropriate Environment Standards (of 8):	N/A:0	CI:0	FA: 8	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 36):	CI:0	FA:17	PA:0	UA:0	NA: 0		

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	FA	0	1	0	0	0	3
Standard 2.2.2	Assessment	FA	0	1	0	0	0	2
Standard 2.2.3	Safe restraint use	FA	0	3	0	0	0	6
Standard 2.2.4	Evaluation	FA	0	2	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	FA	0	1	0	0	0	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 0	CI:0	FA: 6	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 21):	CI:0	FA:9	PA:0	UA:0	NA: 0		

3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management	FA	0	3	0	0	0	9
Standard 3.2	Implementing the infection control programme	FA	0	1	0	0	0	4
Standard 3.3	Policies and procedures	FA	0	1	0	0	0	3
Standard 3.4	Education	FA	0	2	0	0	0	5
Standard 3.5	Surveillance	FA	0	2	0	0	0	8

Infection Prevention and Control Standards (of 5):	N/A: 0	CI:0	FA: 5	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 29):	CI:0	FA:9	PA:0	UA:0	NA: 0		

Total Standards (of 50)	N/A: 0	CI: 1	FA: 47	PA Neg: 0	PA Low: 1	PA Mod: 1	PA High: 0	PA Crit: 0	UA
Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0					
Total Criteria (of 219)	CI: 1	FA: 98	PA: 2	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Ryman Napier Limited
 Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:23-Jul-13 End Date: 23-Jul-13
 DAA: Health and Disability Auditing New Zealand Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.3.4	1.3.4.2	PA Low	<p>Finding: Two residents files reviewed in the SCU (dementia unit) identified that the residents had sustained weight loss. Food charts, weekly weights and high protein drinks were evidenced to be in place for both residents, however nutritional screening tools had not been completed as per Ryman Policy.</p> <p>Action: Ensure clinical risk assessment tools are reviewed/completed when there is a change in resident condition/needs.</p>	3 months
1.3.12	1.3.12.6	PA Moderate	<p>Finding: (i) Gaps were evidenced in two medication signing charts reviewed in SCU (dementia unit). No rationale for medication not signed for/given was documented in progress notes or on the medication signing sheet. (ii) One medication chart reviewed in Duke wing evidenced that a prescribed dose of Controlled medication (M-Eslon) was not given. A review of the controlled drug register confirmed that the medication had not been given as prescribed. One entry on the medication signing chart for a resident on controlled medication recorded the date, time and dose but had not been signed by person administering and checking the medication at time of administration.</p> <p>Action: Ensure medications are signed for at time of administration. Ensure that medications are given as prescribed immediately.</p>	1 month

Continuous Improvement (CI) Report

Provider Name: Ryman Napier Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:23-Jul-13 End Date: 23-Jul-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Evidence
1.3.7	1.3.7.1	<p>Finding:</p> <p>There are six activity coordinators with each coordinator assigned to a specific area (rest home, hospital, dementia unit and serviced apartments). One of the coordinators is a Diversional Therapist. Activities take place in the lounges, gardens (weather permitting) and dining areas. There are also opportunities identified for one on one activities with residents who prefer not to/or are unable to join in group activities. Residents described going out to visit the Aquarium, for afternoon tea to the Age Concern or a local cafe and for picnic lunches. Residents interviewed reported that they have a "Freaky Fridays". This is a non-planned activity that is completely spontaneous. Residents stated it was great fun because they would just turn up and be surprised by the events. These included a trip to the Aquarium, having a visit from some new born lambs, a horse, miniature pigs, having a "funny money auction" and cooking demonstration with audience participation. Family members are invited to join in. Family members and residents interviewed reported that a recent "60's show" held at the facility was a great success. There are entertainers who are booked to come and entertain three times per month usually on Saturdays. Guest speakers are invited to attend the facility and included visits from the Women's' Institute, a horticulturalist and a Travel Agent. Four of the activity team interviewed described the 'Spice of Life' programme, a resident focused programme to enable the village to support residents achieving their own, personalised goals. There is a Spice of Life register and achievement towards resident goals is documented. Interviews with residents identified that they were able to choose goals which they felt would enhance their enjoyment of life or anything that they might like to do.</p> <p>Many residents were observed to have achieved their original goals and have now set themselves new goals. One resident wants to go in a racing car and documentation evidenced that activity staff and family are working together to make this event happen. One resident had stated that their goal was to be fit enough to go on a holiday with her family to Tonga. The Physiotherapist has been involved in developing an exercise programme for the resident to help improve her balance and confidence. This was included as part of the activity programme and the exercise programme has been implemented by the physiotherapy assistant. The trip to Tonga has been organised and the resident has achieved her Spark of Life Goal. Another resident who was unable to mobilise and had visual expressive aphasia following a stroke and had been transferred to the facility from hospital in May 2012 described how the physiotherapy assistant has been actively involved in the rehabilitation of the resident. The resident is now able to walk independently with her frame for long distances and uses a quad stick for short distances. The resident is now reading, knitting and enjoys outings. The resident interviewed states her new goal is that she would like to be able to mobilise just using her quad stick and go dancing.(the resident had been a keen ballroom dancer prior to having a stroke). Residents in the SCU (dementia unit) were observed to be actively involved in activities during the two days of audit. Residents were observed playing ball games, helping with activities such as setting tables and participating in exercises, cooking and enjoying a quiz game.</p>

1. 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

Consumers receive services in accordance with consumer rights legislation.

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) are in place. The service provides families and residents with information on entry to the service. This information contains details relating to the Code. Employees receive training about the Code at induction and through yearly in-service training and competency questionnaires around such areas as medication are completed by staff.

Interviews with seven caregivers (four rest home/hospital, one studio apartment and two dementia) confirm their understanding of the key principles of the Code.

Resident rights/advocacy/open disclosure training was last provided in April 2013 with 29 staff attending. Complaints training was provided to staff in June 2013 with 11 staff attending and training around informed consent took place last in June 2013 (11 attended noting that others have completed training in 2012).

Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>D6,2 and D16.1b.iii The information pack provided to residents on entry include how to make a complaint, a Code of Rights pamphlet, and an advocacy pamphlet.</p> <p>The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. The welcome information booklet/folder includes information about the Code.</p> <p>Families (three hospital level, two rest home and two dementia level) and seven caregivers (four rest home/hospital, one studio apartment and two dementia) report there are opportunities to discuss details relating to the Code at entry, and in regular and on-going discussions with management and staff.</p> <p>Advocacy pamphlets are clearly displayed on the noticeboard on each floor. Advocacy is brought to the attention of residents and families at admission, in the two-monthly resident meetings and in the event of a complaint.</p> <p>Interviews with residents and families confirm that information has been provided around advocacy services.</p>	

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
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Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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 families from the dementia unit state 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 Eleven resident files reviewed identify that cultural and /or spiritual values, individual preferences are identified.

The facility provides physical, visual, auditory and personal privacy for residents. During the visit, staff demonstrated gaining permission before entering resident's rooms. The service has a policy in place that states personal belongings are not used as communal property. Seven caregivers (four rest home, one studio apartment and two dementia) state that they knock before entering a resident's room. This was also observed by the auditors.

Values and beliefs information and resident preferences are gathered on admission with family involvement and is integrated with the residents' care plans. Resident and family if involved sign an acknowledgement form to state that they have been involved in the care planning. This includes cultural, religious, social and ethnic needs. Interviews with seven caregivers identified how they get to know each resident's values, beliefs and cultural uniqueness.

Interviews with 11 residents (four hospital, two studio apartments, five rest home), confirmed that the service actively encourages them to have choices. This includes voluntary involvement in daily activities. Interviews with seven caregivers describe providing choice including what to wear, food choices, how often they want to shower, types of activities they are interested in and whether they want to be involved in activities. The interview with the two caregivers from the dementia unit confirmed that staff take special care to introduce as much choice as possible to the resident.

An abuse and neglect policy is implemented. Staff are required to complete abuse and neglect training as part of the training plan. Abuse and neglect training was last delivered in July 2013 with 27 staff attending.

There is training and questions included in the induction programme on abuse and neglect, which staff have completed. Discussions with 11 residents and seven family members were overall positive about the care provided and state that there is no evidence of any abuse occurring.

Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

A3.2 The Maori health plan includes a description of how the service will achieve the requirements set out in A3.1 (a) to (e). D20.1i The service has developed a link with a cultural advisor (Maori) and the village manager meets with the person at least annually and as issues/events arise. The cultural advisor links with Te Pukemoke and identifies as Ngati Kahungunu. The policies for Māori identify the importance of whānau.

There is also a staff member who provides support from a Maori perspective and the village manager state that Maori staff bless the rooms following a death.

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.

Employees receive cultural training during their induction to the service and as an in-service topic in 2013.

Cultural needs and support are identified in care plans.

Seven of seven caregivers, two registered nurses, one hospital coordinator, one rest home coordinator , one village coordinator and one enrolled nurse (team leader in the dementia unit) understand the importance of family/whanau involvement. Discussions with seven of the seven relatives confirm that they are regularly involved noting that there are no Maori residents currently in the service.

One family member has been involved with the service through a relative who has since passed away and is Maori. They praised the service for the visiting arrangements, for their ability to actively engage in activities of daily living for their family member and for the support their family member and the family received.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

All eleven care plans reviewed (four rest home, four hospital, three dementia) include the residents' social, spiritual, cultural and recreational needs. 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 (sighted in 11 residents' care plans: four hospital, four rest home and three dementia).
D3.1g The service provides a culturally appropriate service by identifying cultural needs in the residents' care plans.
D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.
Residents and family interviewed confirm that their culture and beliefs are respected.
97% of relatives and residents responding in the 2012 satisfaction survey state that staff strive to ensure privacy and dignity most or all of the time.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

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

ARHSS D16.5e

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Staff employment policies/procedures include rules on receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. Two registered nurses, one hospital coordinator, one rest home coordinator, village coordinator and one enrolled nurse (team leader in the dementia unit) interviewed were able to describe appropriate boundaries between staff and residents and their families.

Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem.

Caregivers are able to describe how they build a supportive relationship with each resident (evidenced in interviews with seven of seven caregivers). This applies to caregivers in the dementia unit as well (two of two interviewed) who confirm that that they often have to develop a sense of security over and over again for residents.

Interviews with family confirm that staff assist to relieve anxiety for residents in the dementia unit.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Ryman has robust quality and risk management processes, which are well implemented at Princess Alexandra Retirement Village. The RAP programme is directed from head office. Six monthly comparative incident and accident reports and infection reports are completed. Policies and procedures cross-reference other policies and appropriate standards. There is a RAP committee at Ryman head office that reviews best practice, legislation, standards, research, and policy and procedure review. All changes made to policy, procedures and processes are forwarded to the village manager for input and review. The village manager ensures that the registered nurses and enrolled nurses receive the information prior to the meeting to discuss and this is also communicated at the full staff meeting monthly. Ryman objectives include a major focus across the organisation is to fully train their workforce. The education programme provided to staff includes an evaluation of sessions and competency assessments. There is a journal club for the registered nurses and enrolled nurses at Princess Alexandra Retirement Village. Relevant articles/research and questions, directed by head office, are completed at the journal club. The most recent journal club topic was UTIs and informed consent. There is evidence of clinical development and review of practice. The focus of care utilises a multidisciplinary model and includes input from residents, relatives, caregivers, registered nurses, and GPs. All caregivers are encouraged and supported to complete the Aged Care Education (ACE) foundations within a one-year time frame and all household staff (11) are enrolled in the ACE dementia programme. 36 of the 86 caregivers have their ACE or national certificate qualifications and 39 caregivers and 11 housekeeping staff are enrolled in the ACE programme. All caregivers who have worked in the dementia unit for more than one year have their ACE Dementia qualifications. Ryman has also implemented a management development programme for their managers. Princess Alexandra Retirement Village is participating in the ACC Vitamin D initiative to reduce effects of falls in the elderly. For 2013 there is a collective national plan in place for twice yearly multi-disciplinary meetings to be held with families to discuss a range of clinical and non-clinical topics. This is an additional two specific GP meetings held twice yearly. The service has supported the activity team to implement Spice of Life (A resident focused programme to enable the Village to support residents achieve self-set goals). There is a spice of life register to assist care staff to focus on spice of life goals. The service continues to implement the wound care assessment tools and paperwork including wound care workbook for registered staff to complete. There is a wound care champion selected to be on-site reference point for wound care. Wounds are discussed at weekly management meeting to ensure all wounds are being managed and discussed frequently. The service has specifically targeted reducing the use of restraint in the dementia unit with a 50% decrease in the use in the past year. The unit has focused on alternative ways of managing challenging behaviour with strategies well documented in the resident care plan and in the behavioural management plans. An assistant manager has been employed specifically to support the village manager and to facilitate training for staff.

A2.2 Services are provided that adheres to the health and disability services standards. There are implemented quality improvement programmes that include performance monitoring at an organisational and service level.

D1.3 All approved service standards are adhered to.

D17.7c There are implemented competencies for caregivers, enrolled nurses and registered nurses and a well implemented training plan. There are clear ethical and professional standards and boundaries within job descriptions.

Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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 families including if an incident or care/medical issue arises.

Access to interpreter services is identified in the community and through the DHB interpreting services. There is one Indian resident who does not require interpreting services (confirmed on interview with the resident and family member). Multi-cultural staff are also able to interpret for some residents when needed and if required. During this audit, there were no residents requiring an interpreter.

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.

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 are not covered by the agreement.

D16.4b Seven relatives report that they are kept informed when their family members health status changes. This is confirmed on review of 12 incident forms reviewed which includes that family have been contacted after the incident (at the earliest possible time).

D11.3 The information pack is available in large print and advised that this can be read to residents.

Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**Audit Evidence****Attainment:** FA**Risk level for PA/UA:****Finding Statement**

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 Informed Consent

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?**Attainment:** FA

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with seven caregivers (four rest home, one studio apartment and two dementia), identify that consents are sought in the delivery of personal cares and this is confirmed by eleven residents. Written consent includes the signed admission agreements and medical care guidance plan and care plans acknowledgement document. All 11 resident files reviewed had signed consent forms. Advanced directives / resuscitation policy is implemented in all 11 resident files reviewed.

D13.1 there were 11 admission agreements sighted and all had been signed on the day of admission

D3.1.d Discussion with seven family members (three hospital level, two rest home and two dementia level) identified that the service actively involves them in decisions that affect their relatives lives.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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. A relative or nominated advocate is documented on the front page of the residents' file.

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

ARC D4.1e: The resident file includes information on residents, family/whanau and chosen social networks as sighted in 11 of 11 files reviewed.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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; Discussions with seven families confirm that they are encouraged to be involved with the service and care.

D3.1.e Discussions with seven of seven caregivers and four activities staff along with seven relatives confirm that residents are supported and encouraged to remain involved in the community and external groups such as the RSA and church groups noting that there are few residents who continue with this in the hospital and rest home particularly.

One family member praised the service for the support to engage with their family member at the end of life.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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

E4.1biii. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint, behaviour management and management of complaints.

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 an electronic system (VCare).

Complaints and verbal complaints reviewed for 2013 are tracked for monitoring purposes to ensure that they are actioned according to timeframes determined by the code of rights, and identify when a complaint is resolved.

In total, three complaints were reviewed to ensure timeframes in policy are met. All complaints reviewed reflect appropriate actions taken within the allotted time frames.

There are no complaints with the Health and Disability Commissioner as confirmed by the village manager.

Residents and family interviewed state that they know how to make a complaint. Two state that they have raised a concern and this has been addressed promptly.

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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Princess Alexandra Retirement Village is a modern facility that is part of a wider village. The service provides care across three service levels (rest home, hospital -medical geriatric and dementia-level care) for up to 138 residents. The care centre includes 84 hospital/rest home beds on the ground floor (60 swing beds) with a 24 bed dementia unit. There are potentially 30 serviced apartments able to be used to provide for rest home care included in the total number of beds available. The current occupancy on the days of the audit is 36 hospital, 48 rest home including six in the serviced apartments, 24 dementia unit residents (total 108 residents).

There are no residents identified as requiring medical geriatric care or who were under the age of 65 years.

Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. For purposes of monitoring organisation performance, the village manager reports weekly to head office. The 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 programme (RAP) is designed to monitor contractual, standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting.

The facility manager (RN) is an experienced manager who commenced employment with Ryman at the Princess Alexandra Retirement Village facility in September 2009. She has a Dip Midwifery, Dip Community Health and Dip Hospital Administration. She attends Ryman training three times a year. Ryman also offers managers an opportunity to identify areas to improve and individual training around specific areas is provided. The manager's previous experience includes general manager, fundraising and marketing roles. She is supported by an assistant manager (enrolled nurse), hospital coordinator (registered nurse) and a rest home coordinator (registered nurse) and a village coordinator (enrolled nurse) who also supports the serviced apartments. The team leader in the dementia unit is an enrolled nurse.

The Management Resource Manual includes a number of documented responsibilities of the manager including a list of reporting requirements. There is a manager's job description.

The management team is supported by the Ryman Regional Manager (RN) and Ryman Systems Manager.

The Ryman Managers complete a leadership and management course (an initiative by Ryman) that includes a number of modules, including self-directed learning packages.

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

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

There are business objectives monitored throughout the organisation.

Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.2.2 Service Management

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
During the temporary absence of the village manager, the assistant manager (enrolled nurse) undertakes the role of village manager with administrative support. She has on-going training via the induction programme and attends any ad hoc training specific to the village with external training as appropriate. She attends the Ryman Accreditation Programme (RAP), management meetings and full facility meetings to ensure participation in the Ryman Accreditation Programme. The role was developed to take responsibilities for specific aspects of the operational running of the village and oversees the village when the village manager is away. She has been in role for three months noting that this is a new Ryman role since May 2013. D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.	

Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.3 Quality And Risk Management Systems

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Princess Alexandra Retirement Village has a well-established 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 Princess Alexandra Retirement Village at the onsite monthly RAP meetings and weekly management meetings.

Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with two registered nurses, one hospital coordinator, one rest home coordinator and one enrolled nurse (team leader in the dementia unit) and seven caregivers; and review of meeting minutes demonstrates staff involvement in quality and risk activities.

The monthly staff meeting (full facility RAP meeting) includes discussing and planning quality goals for the year (meeting minutes sighted).

Resident meetings are held two-monthly in the rest home and in the hospital. Relative meetings are held six monthly. Minutes are maintained. There is evidence of sign off of corrective actions for meetings noting that because there are few relative meetings with different family attending, the service finds it more difficult to feedback specifically to those who have attended.

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 on quality improvement.

Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar.

Clinical policies and procedures are in place for the rest home, dementia unit and hospital. The two monthly journal club (attended by registered and enrolled nurses and directed by head office) reviews the latest clinical practice articles. Journal topics are a reflection of the current environment. Topics that have been covered in the past six months include informed consent and urinary tract infections.

There are policies and tools for the following: continence management, pain management, personal grooming and hygiene, skin integrity management policy and a pressure risk assessment tool, wound care, transportation of subsidised residents and death and dying. There is a policy around challenging behaviour.

The service has a comprehensive quality system that is implemented. A RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. a) There are comprehensive monthly accident/incident reports completed that break down the data collected across each area in the facility. Reports are provided from the manager to head office that includes a collation of staff incidents/accidents and resident incidents/accidents. A six monthly comparative summary report includes recommendations for residents and staff, and training conducted. These are also compared with the previous month. There is also an organisational report produced six monthly that benchmarks incidents/accidents across the organisation. b) The monthly manager's report includes complaints/concerns/compliments. All complaints are attended to through the monthly RAP meeting. Quality improvement plans are initiated where required. c) All infections are documented in a monthly summary report and discussed in the monthly RAP committee meetings and monthly health and safety/IC meetings. 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 meetings. The hazard register is attached and this includes problems and resolution. e) The restraint approval group at Princess Alexandra Retirement Village is held six monthly with minutes documented. An internal audit is completed six monthly.

Comprehensive quality and risk management programmes are in place. Systems for monitoring infection control, quality improvements, health and safety, service delivery, resident rights, managing service delivery, emergency and human resources are in place. Monitoring in each area is completed monthly, six monthly or annually as designated by the RAP programme schedule.

Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six-month period. Reports and implementation of the quality system is monitored closely by head office.

The service continues to collect data to support the implementation of corrective action plans. The internal auditing annual schedule is implemented as per schedule. There is a six monthly spot internal audit with evidence that findings are used as part of the quality improvement plan.

Meetings are minuted including actions to resolve 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. Meetings include the following: monthly RAP, full facility, activities, clinical in each area (rest home, hospital, apartments, dementia), enrolled nurse/registered nurse; two monthly health and safety including infection control, resident; six monthly restraint and six monthly family meetings.

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. Risk management, hazard control and emergency policies and procedures are in place. Ryman has tertiary level ACC WSMP to November 2013.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

D19.2g Falls prevention strategies such as sensor mats, staff supervision and monitoring of falls are in place.

Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
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Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.

This shall include, but is not limited to:

- (a) Event reporting;
- (b) Complaints management;
- (c) Infection control;
- (d) Health and safety;
- (e) Restraint minimisation.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
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Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4 Adverse Event Reporting

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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. The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH.

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required as sighted in 12 incident forms reviewed.

The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Meeting minutes across the range of meetings that take place reflect discussions of incidents/accidents and actions taken.

A six monthly comparative analysis is completed of incidents for internal benchmarking across Ryman's facilities. In addition, each facility receives an analysis of the last three six monthly periods from which to identify trends and improvements. Falls rates are compared to indicators from the "Standard on safe indicators in aged care".

A review of incident/accident forms for Princess Alexandra Retirement Village identifies that 12 of 12 incident forms are fully completed and include follow-up actions taken.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eleven of eleven staff files were reviewed (one chef, one assistant manager, one registered nurse, eight caregivers, two enrolled nurses). All staff files included relevant induction books, referee checks, training, and development records.

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.

Princess Alexandra Retirement Village 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 caregiver, senior caregiver, registered nurse, health and safety representative, coordinators and activities. The orientation/induction training for caregivers, on completion, provides them with a level two national certificate in support of the older person.

There is an implemented education plan (sighted for 2012 and 2013). The annual training programme well exceeds eight hours annually.

All caregivers are encouraged and supported to complete the Aged Care Education (ACE) foundations within a one-year time frame and all household staff (11) are enrolled in the ACE dementia programme. 36 of the 86 caregivers have their ACE or national certificate qualifications and 39 caregivers and 11 housekeeping staff are enrolled in the ACE programme. All caregivers who have worked in the dementia unit for more than one year have their ACE dementia qualifications.

Yearly formal performance reviews are in place for reflective practice and setting goals including up skilling or other training or qualification goals. Registered nurses are supported to maintain their professional competency.

The journal club for registered nurses and enrolled nurses meets two-monthly. Research articles are reviewed and specific questions are assigned for discussion. Interviews with the coordinators, team leader dementia and registered nurses/enrolled nurses identifies that participation in the registered nurse journal club is used to advise current practice and provide clinical updates and guidance.

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

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

E4.5f: All caregivers working in the dementia unit have completed the required dementia standards. Three caregivers were identified as not having completed dementia training a week prior to the audit and they have been replaced with staff who have completed the training.

Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has a policy around 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.

Interviews with seven caregivers across the four areas (two dementia, one studio apartment, two hospital/rest home) state that overall the staffing levels are 'OK' although they are kept very busy. They report the registered nurses and enrolled nurses (including coordinators and team leader) provide good support. Seven relatives state that staff are readily available to meet their family's needs.

Registered nursing staff are provided 24 hours a day, seven days a week.

The following staff are on duty:

Dementia unit (24 beds): AM - 1 team leader (enrolled nurse), 3 caregivers (two full shift and one short); PM - 4 caregivers (two full and two until 8pm or 9pm); Night: 2 caregivers.

Hospital/rest home (24 beds): AM - 1 registered nurse, 4 caregivers (two full shift and 2 short); PM - 1 registered nurse, 3 caregivers (two full and two over dinner time); Night: 2 caregivers.

Hospital/rest home (60 beds): AM - 2 registered nurses, 9 caregivers (4 full shift and 5 short); PM - 1 registered nurse, 7 caregivers (3 full); Night: 1 registered nurse and 3 caregivers.

The serviced apartments have six rest home residents who are supported by the team leader and 2 caregivers AM, 2 caregivers in the afternoon and by staff in the 24 bed hospital/rest home wing after 10pm and overnight. The six residents are on floors two and three. Two rest home residents from the apartments state that they are well supported and their call bells are answered in a timely manner. There is a call bell audit that monitors response to the bell and this indicates that call bells are answered in a timely manner.

One of the 11 residents and one staff member states that there are insufficient staff on duty at all times however all other staff and residents interviewed state that there are sufficient to provide support and to attend to cares.

Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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 secure cupboards behind the nurses' station 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, enrolled nurse, registered nurse or other staff including designation.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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. Information gathered at admission is retained in resident's records.

Four rest home, five hospital and two residents from serviced apartments (assessed as rest home level care) interviewed confirmed they received information prior to admission and discussed the admission process with the manager.

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

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

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

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 Three dementia resident files were reviewed and both included a needs assessment as requiring specialist dementia care.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.2 Declining Referral/Entry To Services

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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 and service delivery policy and nursing care assessment and planning interventions policy describes the responsibility around documentation.

Wound care folders evidenced in all three areas (Duke, Duchess and the Secure Care Unit) and assessments are signed by a registered nurse. Activity assessments and activities care plans have been completed by the activity therapists.

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

D16.2, 3, 4; The initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe in all eleven resident files reviewed which included four rest home (two serviced apartment), four hospital and three dementia). The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. Eight of 11 resident files evidence six month evaluations (three files were newer admissions).

D16.5e; Medical assessments were documented in all eleven resident files within 48 hours of admission. One- three monthly medical reviews were documented in the eleven resident files by general practitioners. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

A file was reviewed of a hospital resident end of life that had the Liverpool care pathway implemented. This was well documented by staff including pain management, involvement in family and coordination of care.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a Duty Handover Supplement document which is completed for each shift that lists staff allocations, notes any residents requiring any special observations or needs and also advises of who is on call and who is the designated fire warden for that shift. There is a house GP (medical centre) involved with the service that visits weekly or more frequently if needed. A village coordinator who is an enrolled nurse is responsible for residents in the services apartments which further clinical oversight provided by the rest home coordinator (RN). Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Eleven files reviewed evidence this is occurring. A weekly management meeting provides an opportunity to discuss any clinical issues, infection control, wounds and restraint are also included as agenda items for discussion.

The physiotherapist visits weekly and a physiotherapy assistant provides physiotherapy five days a week as directed by the physiotherapist.

One GP interviewed stated that coordination of care is good and there is good overall clinical leadership.

Tracer Methodology:

Hospital resident:

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

Rest Home:

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

Dementia:

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

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

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

Risk assessment tools and monitoring forms are available and implemented to assess level of risk and required support for residents including (but not limited to); Waterlow pressure area risk assessment, Coombes falls assessment, pain assessment, continence assessment, skin integrity, cultural assessment and nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly. The nursing care assessment policy provides guidance in the use of assessment tools. There is an improvement required around the completion/review of assessments completed when there is a change in resident condition/need.

A care plan acknowledgement document identifies involvement of family in the assessment and care planning process. (these were evidence on all files reviewed).

An initial support plan is completed within 24 hours. The nursing assessment links to the care plan and this was evident in the eleven long term care plans reviewed. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation.

ARC E4.2; Three resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements. All three had a comprehensive behaviour assessment and management plan.

Criterion 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.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Risk assessment tools and monitoring forms are available and implemented to assess level of risk and required support for residents including (but not limited to); Waterlow pressure area risk assessment, Coombes falls assessment, pain assessment, continence assessment, skin integrity, cultural assessment and nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly. The nursing care assessment policy provides guidance in the use of assessment tools.

Finding Statement

Two residents files reviewed in the SCU (dementia unit) identified that the residents had sustained weight loss. Food charts, weekly weights and high protein drinks were evidenced to be in place for both residents; however nutritional screening tools had not been completed as per Ryman Policy.

Corrective Action Required:

Ensure clinical risk assessment tools are reviewed/completed when there is a change in resident condition/needs.

Timeframe:

3 months

STANDARD 1.3.5 Planning

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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.

Each area of the care plan includes: problems/needs, objectives and interventions. The 11 files (four hospital, four rest home, three dementia) reviewed reflected 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 speech language therapist, physiotherapist, podiatrist, dietitians and MHSOP. Resident medications and medical status are reviewed one- three monthly by the General Practitioners. Activity therapists maintain activity assessment/care plans and evaluation in residents file. There are specific physiotherapy progress notes.

E4.3 Three dementia resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k Short term care plans are in use for changes in health status.

All three resident files reviewed in the dementia unit (special care unit) had comprehensive behaviour management plans.

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.3.6 Service Delivery/Interventions

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
Eleven resident files were reviewed (four rest home, four hospital and three from the dementia unit).	

Rest home samples included; a) resident assessed as a high falls risk, b) resident with a wound, c) rest home resident in the serviced apartments, d) resident on controlled medication.

Hospital samples include; a) resident requiring PEG feeds, b) resident with an infection (UTI), c) resident d) resident with restraint.

Dementia samples included; a) Resident with challenging behaviours b) resident with weight-loss, Grade IV pressure areas assessed as hospital level care and is awaiting placement c) resident requiring the administration of controlled medications as part of prescribed pain management plan.

Five of six resident files reviewed with current wounds showed a link between short term care planning and wound management plans . Grade IV pressure area has had input from clinical wound care specialist and GP. Appropriate pressure relieving equipment and strategies are in place. Including pressure relieving mattress, review of nutritional assessment and frequent changes of position. D18.3 and 4 Dressing supplies are available and a treatment rooms in each area are stocked for use.

Contenance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Contenance management in-services and wound management in-service have been provided.

Wound folders were reviewed in each area and the following wound assessment and wound management plans were sited; 1) Duke - three skin tears, and one skin excoriation; 2) Duchess - four skin tears, one surgical wound (skin graft), one grade two pressure area, one laceration, and two SCC; 3) Dementia - two skin tears and one grade four pressure area.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Strategies for the provisions of a low stimulus environment could be described by staff interviewed from the dementia unit.

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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: CI

There are six activity coordinators with each coordinator assigned to a specific area (rest home, hospital, dementia unit and serviced apartments). One of the coordinators is a Diversional Therapist.

Activities programmes are planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences', Next of kin input into care and an activities care plan. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. The activities programme is comprehensive, meeting the individual needs of the residents. The programme is evaluated and can be individually tailored according to residents' needs.

The activity team described the 'Spice of Life' programme, a resident focused programme to enable the village to support residents achieving their own, personalised goals. Residents are able to participate in community activities as well as activities in the service itself.

Activities include (but not limited to): outings, triple A exercise, programme, music, crafts, shopping, happy hour, reading, and quizzes.

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. Residents were observed enjoying a triple A session. There are different levels of the programme depending on the mobility level of the residents.

Resident meetings are held in the hospital and rest home bi-monthly and feedback to activities is also provided at the meeting

Eleven residents and seven family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Audit Evidence

Attainment: CI

Risk level for PA/UA:

There are six activity coordinators with each coordinator assigned to a specific area (rest home, hospital, dementia unit and serviced apartments). One of the coordinators is a Diversional Therapist.

Activities programmes are planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.

Finding Statement

There are six activity coordinators with each coordinator assigned to a specific area (rest home, hospital, dementia unit and serviced apartments). One of the coordinators is a Diversional Therapist. Activities take place in the lounges, gardens (weather permitting) and dining areas. There are also opportunities identified for one on one activities with residents who prefer not to/or are unable to join in group activities. Residents described going out to visit the Aquarium, for afternoon tea to the Age Concern or a local cafe and for picnic lunches. Residents interviewed reported that they have a "Freaky Fridays". This is a non-planned activity that is completely spontaneous. Residents stated it was great fun because they would just turn up and be surprised by the events. These included a trip to the Aquarium, having a visit from some new born lambs, a horse, miniature pigs, having a "funny money auction" and cooking demonstration with audience participation. Family members are invited to join in. Family members and residents interviewed reported that a recent "60's show" held at the facility was a great success. There are entertainers who are booked to come and entertain three times per month usually on Saturdays. Guest speakers are invited to attend the facility and included visits from the Women's Institute, a horticulturalist and a Travel Agent. Four of the activity team interviewed described the 'Spice of Life' programme, a resident focused programme to enable the village to support residents achieving their own, personalised goals. There is a Spice of Life register and achievement towards resident goals is documented. Interviews with residents identified that they were able to choose goals which they felt would enhance their enjoyment of life or anything that they might like to do. Many residents were observed to have achieved their original goals and have now set themselves new goals. One resident wants to go in a racing car and documentation evidenced that activity staff and family are working together to make this event happen. One resident had stated that their goal was to be fit enough to go on a holiday with her family to Tonga. The Physiotherapist has been involved in developing an exercise programme for the resident to help improve her balance and confidence. This was included as part of the activity programme and the exercise programme has been implemented by the physiotherapy assistant. The trip to Tonga has been organised and the resident has achieved her Spark of Life Goal. Another resident who was unable to mobilise and had visual expressive aphasia following a stroke and had been transferred to the facility from hospital in May 2012 described how the physiotherapy assistant has been actively involved in the rehabilitation of the resident. The resident is now able to walk independently with her frame for long distances and uses a quad stick for short distances. The resident is now reading, knitting and enjoys outings. The resident interviewed states her new goal is that she would like to be able to mobilise just using her quad stick and go dancing.(the resident had been a keen ballroom dancer prior to having a stroke). Residents in the SCU (dementia unit) were observed to be actively involved in activities during the two days of audit. Residents were observed playing ball games, helping with activities such as setting tables and participating in exercises, cooking and enjoying a quiz game.

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The evaluation and care plan review policy require that care plans are reviewed six monthly. The Vcare evaluation template describes progress against every goal and need identified in the care plan (sited). Short term care plans are well utilised in the rest home, hospital, and dementia unit. Any changes to the long term care plan are dated and signed. Care plans reviewed included handwritten updates to the plan as needs have changed (also link 1.3.6.1).

Short term care plans were evidenced completed for wounds, weight loss, poor appetite, and infections.

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

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

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated by the service. The referral is co-ordinated by the clinical leader with input from registered nurses, when the referral is not to a specialist. A letter from the GP is then required. 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. Referral to higher level of care was identified in one resident file reviewed in the dementia unit who is awaiting placement for hospital level care. Family are viewing facilities with a vacancy, and will then choose and inform Princess Alexandra of their decision.

D 20.1 discussions with the hospital and rest home coordinators, two registered nurses and two enrolled nurses identified that the service has access to (but not limited to); physiotherapist, wound care specialist, MHSOP, geriatrician, speech language therapist, hospice nurses and dietitian.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

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

ARC D21 ARHSS D21

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Transfer information is completed by the registered nurses or the hospital and rest home coordinators and communicated to support new providers. 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 was reviewed of a resident transferred acutely to hospital identified that a transfer form was completed and family notified. Seven relatives (three hospital, two dementia and two rest home), 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 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN in the hospital, dementia unit, serviced apartment and rest home. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications.

Medication administration was observed in the hospital, dementia unit, rest home and serviced apartments. Medications and associated documentation is kept in the locked medication trolley in all areas including the serviced apartments. Medication trolleys are stored in locked treatment rooms when not in use.

RN's in the hospital and senior caregivers/RN/EN in the rest home/dementia unit and serviced apartments deemed competent are responsible for administering medication. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.

Controlled drugs are stored in a locked cabinet inside a locked treatment room on each floor. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly. Medication fridge's are monitored weekly in each area.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. This was cited in the respite file reviewed. Resident photos and allergies are on all the drug charts.

All senior caregivers/RNs administering medication complete a medication package. An annual medication administration competency is completed of each staff member. Medication competence assessments were completed in January 2013.

There is a self-medicating resident's policy in place. A self-medication assessment checklist is available and has been completed and reviewed six monthly for the one resident in the rest home who self-administered inhalers.

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

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

Improvements are required to ensure that medications are signed for at time of administration and that medications are given as prescribed.

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: PA	Risk level for PA/UA: Moderate
Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards.		
D16.5.e.i.2; Twenty two medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.		
Finding Statement		
(i) Gaps were evidenced in two medication signing charts reviewed in SCU (dementia unit). No rationale for medication not signed for/given was documented in progress notes or on the medication signing sheet. (ii) One medication chart reviewed in Duke wing evidenced that a prescribed dose of Controlled medication (M-Eslon) was not given. A review of the controlled drug register confirmed that the medication had not been given as prescribed. One entry on the medication signing chart for a resident on controlled medication recorded the date, time and dose but had not been signed by person administering and checking the medication at time of administration.		
Corrective Action Required:		
Ensure medications are signed for at time of administration. Ensure that medications are given as prescribed immediately.		
Timeframe:		
1 month		

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

All kitchen staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller and a pantry. The menu is designed and reviewed by a Registered Dietitian at an organisational level. There is a four weekly rolling menu.

All meals are cooked in the main kitchen and are transferred to the rest home, hospital and dementia units in insulated containers. Trays of food are then removed from the insulated transfer boxes and placed in warmed bain maries. Caregivers serve the food from bain maries in kitchenette areas in each unit. There are also snacks available over 24 hours for residents.

Diets are modified as required. kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed bi annually. 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. Fridge/food temp audit January 20 13 100%, kitchen hygiene & food storage audit 100% January 2013.

Residents with special dietary needs have a nutritional profile completed on admission. This is reviewed six monthly as part of the care plan review. Changes to resident's dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Alternatives are provided.

Interviews with six rest home and five hospital residents overall spoke positively about the food service.

E3.3f, Additional snacks are available in the dementia unit and can be accessed by staff for residents.

D19.2 staff have been trained in safe food handling.

Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		

Corrective Action Required:

Timeframe:

Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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.

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.4.2 Facility Specifications

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The building holds a current warrant of fitness which expires on 30-Jul-13. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2013. Health and Safety meetings include maintenance and preventative maintenance. The Duchess, Duke and the Special Care unit are all on ground level. Serviced apartments are located on the two upper levels. 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 appropriately installed. 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 with paths and handrails. E3.4d; The lounge area is designed so that space and seating arrangements provide for individual and group activities. E3.3e; There are quiet, low stimulus areas that provide privacy when required. E3.4.c; There is a safe and secure outside area that is easy to access

Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms in Duke and Duchess Units have ensuites. Rooms in the Special care unit (dementia) do not have ensuites. Communal toilets are located near the lounges in all areas.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Each area has at least two lounges. There is also a family room and separate dining area in each unit. 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. Seating and space is arranged to allow both individual and group activities to occur.

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

Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are Housekeeping, and laundry policies and procedures in place. The laundry has an entrance for dirty laundry and an exit for clean. The laundry is designed to have a dirty to clean flow. There are procedures for the management of the machinery. The Ecolab manual includes instructions for cleaning. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Laundry and cleaning processes are part of the internal audit programme.

The service has a secure area for the storage of cleaning and laundry chemicals. Chemicals are labelled. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are displayed in the laundry and chemical storage areas. The laundry and cleaning areas have hand-washing and drying facilities.

The relative satisfaction survey completed in 2012 identified that 98% of respondents were very satisfied with the cleanliness of the facility.

Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.4.7 Essential, Emergency, And Security Systems

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

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
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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 are included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Last fire drill occurred 12-Jun-13.

The fire service approved the evacuation plan on 26-Oct-06. The service has alternative cooking facilities (gas cooker, BBQ,) 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 ample water storage available on site (three litres per person per day for three days). The civil defence folder, located at the nursing stations, 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).

The serviced apartments also include call bells in resident rooms and ensuites. Those residents assessed as requiring rest home level care in the serviced apartments are given a call bell pendant so that a call bell is always accessible. Emergency call bells, sensor mat and chair alarm testing record audit was completed in February 2013 and attained 100%.

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 that 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.

There is an entrance and foyer area on entering the dementia unit.

Visitor's book and resident sign out book available. The Ryman group has a security checks policy and procedure.

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

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility. All rooms have external windows with plenty of natural sunlight. Residents and families interviewed confirmed that the facility is always warm and well ventilated.

Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The Ryman Restraint Minimisation Manual is applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, including definitions, processes and use of enablers.

The Restraint Minimisation Manual includes that enablers are voluntary and the least restrictive option. There are seven enablers (bedrails) in use five in Duchess Wing and two in Duchess wing. Two enabler files were reviewed and included consents and an assessment. Enabler use is reviewed six monthly.

There are 11 residents requiring the use of a restraint (bed rails and chair brief restraint). Three restraint files reviewed included completed assessments and consents.

Strategies are in place to minimise the use of restraint including sensor mats, electric beds, mobility aids and monitoring of residents.

E4.4a The care plans reviewed from the SCU (dementia unit) focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. The service has specifically targeted reducing the use of restraint in the dementia unit with a 50% decrease in the

use in the past year. There are seven residents in the SCU (dementia unit) who require the use of a restraint which includes the use of chair supports and bedrails.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 2.2 SAFE RESTRAINT PRACTICE

Consumers receive services in a safe manner.

STANDARD 2.2.1 Restraint approval and processes

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The restraint coordinator is a registered nurse. She has signed a restraint coordinator position description. Assessment and approval processes for a restraint intervention includes input from the RN, resident/or representative and medical practitioner.

Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.2 Assessment

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

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. A registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Consent for the use of restraint is completed with evidence of family involvement. A 'consent for enabler / restraint' form is used to document approval. These were sighted in the three restraint files where restraint is being used.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.3 Safe Restraint Use

Services use restraint safely

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified. An assessment form/process is completed for all restraints. The three files reviewed (one dementia, two hospital) had a completed assessment form and care plans that reflect risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the three files reviewed. The three files reviewed have a consent form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms had been completed. A three monthly evaluation of restraint is completed that reviews the restraint episode.

The service has a restraint and enablers register for the facility that is updated each month.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.4 Evaluation

Services evaluate all episodes of restraint.

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has documented evaluations of restraint every month. The restraint process considers the items listed in # 2.4.1. In the three restraint files reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator. A restraint evaluation is completed for each resident using restraint. Evaluation timeframes are determined by risk levels (e.g., bedrails are reviewed three monthly and chair supports are reviewed monthly). The evaluations had been completed in the two files reviewed with the resident, family, restraint co-ordinator and medical practitioner.

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 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.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 2.2.5 Restraint Monitoring and Quality Review

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

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

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported to the monthly RAP meetings and twice yearly restraint approval group.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

STANDARD 3.1 Infection control management

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There is policies including (but not limited to); a) a scope and application of the NZ standard for IC policy, b) infection control management policy, c) infection control governance policy, and d) defined and documented IC programme policy. There are clear lines of accountability to report to the IC team on any infection control issues including a ' reporting and notification to head office policy. There is an IC responsibility policy that includes chain of responsibility and an IC Officer job description. The defined and documented IC programme policy states that the IC programme is set out annually from head office and is directed via the Ryman Accreditation Programmes annual calendar.

The annual review policy states IC is an agenda item on the two monthly head office H&S committee. Princess Alexandra also undertakes a six monthly comparative summary report on all infections that is reported to staff.

The service infection control manual includes a policy on a) admission of resident with potential or actual infections policy, b) infectious hazards to staff policy, c) outbreak management d) staff health policy and e) isolation policy. The IC officer could describe how they managed previous outbreaks (reports sighted) for gastro outbreak October 2012.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The infection control officer could describe access to Infection Control specialist through the local hospital. Ryman's management team and GP input into infection control when required. The IC officer has attended study days with Bug control and accesses further training through Ryman journal club.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3 Policies and procedures

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is comprehensive infection control policies that supports the Infection Control Standard SNZ HB 8134:2008. There are modified dates identified for all infection control policies and procedures. Policies are documented as reviewed October 2011. The policies include written material relevant to the service. The infection control policies link to other documentation and uses references where appropriate. There are policies for IC management, b) implementing the IC programme, c) education, d) surveillance, and e) overall IC general policies and procedures

D 19.2a: Infection control policies include (but not limited to); a) There are hand hygiene policies including antiseptic and routine or social. There is also a diagrammatic instructions, b) standard precautions policy includes; hand washing, gloves, barrier protection, additional precautions for highly transmissible pathogens, assessment of staff compliance, isolation, cohorting, transport of infected residents, resident and visitor education and handling of linen, equipment and waste;

c) There are a number of transmission based precautions policies in place including (but not limited to); infectious hazards to staff policy, d) staff health policy and staff health guidelines, e) antimicrobial usage policy, f) outbreak management policies and procedures, g) cleaning, disinfection and sterilising of equipment policy, decontamination policy, disinfections policy, h) single use items policy, and i) construction projects/renovations policy.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Infection control training is provided by the infection control officer. Training included MRO organisms Sept 12, and Ecolab (July 12). Hand washing assessments of staff are completed annually. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Resident and relative meeting minutes include feedback on infection prevention and control.

Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.5 Surveillance

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

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The Surveillance policy states the routine/planned surveillance programme is organised and promoted via the RAP calendar. The IC/H&S committee meet monthly and also act as the IC committee. A monthly infection summary report is completed. The Surveillance includes a) systematic surveillance, b) response to surveillance activities, c) development of the surveillance programme, d) standardised definitions, e) surveillance methods, f) reports and g) assessment of effectiveness of surveillance.

Surveillance methods and processes including implementation of an internal audit are appropriate for the size of this facility (rest home and hospital and dementia level). All infections are collected via the 'infection report form' and all collected and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report of generated. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.

The IC Officer then completes a monthly infection summary which is discussed at RN and H&S/IC meetings and a six monthly comparative summary is completed and forwarded to head office. All meetings held at Princess Alexandra includes discussion on infection control. Internal audits are completed hand washing audit April 13, laundry hygiene audit March 13, Kitchen hygiene audit Jan 13. Infections are benchmarked across the organisation.

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe: