**Malvina Major Retirement Village Limited**

**Current Status:** **22-Aug-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**

Malvina Major is a modern facility that is part of a wider village and is one of Ryman Healthcare villages. The service provides care for up to 120 residents across two floors. Additionally, there are 20 certified serviced apartments. Occupancy is 58 rest home residents including four residents assessed as rest home level care in serviced apartments and 66 hospital residents.

There is an acting village manager (regional manager) in place until the position of village manager has been recruited and appointed. The Ryman clinical support manager has been at the facility for two weeks to assist with the implementation of corrective actions identified at a recent HealthCERT inspection which occurred 30-Jul-13. The facility has made some progress towards the addressing the corrective actions identified including on-going review of clinical risk assessment tools, reviewing and updating care plans for each resident, updating of the complaints register and aspects of human resource management.

This audit identified improvements required around the management of resident files, the completion of cultural assessments, implementation of quality systems, appraisals, mentoring of registered nurses, aspects of care planning documentation, use of short term care plans, management of waste, cleaning schedules, restraint and infection control.

**Audit Summary AS AT** **22-Aug-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 |
|  | 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 |

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| **Consumer Rights** | Day of Audit  22-Aug-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit  22-Aug-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. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  22-Aug-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** |

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| **Safe and Appropriate Environment** | Day of Audit  22-Aug-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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  22-Aug-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** |

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| **Infection Prevention and Control** | Day of Audit  22-Aug-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. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

**Audit Results AS AT** **22-Aug-13**

**Consumer Rights**

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. There are policies and processes to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There are improvements required around residents’ files management, management of staff handover, information in married couple’s files. There is a Maori strategic plan. There is an improvements required around Maori cultural information in assessments. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time.

There is a complaints policy that is being implemented and a review of the complaints register indicates that this has been updated following issues identified in a recent HealthCERT inspection audit.

**Organisational Management**

There is an acting village manager in place who is an enrolled nurse with experience in managing Ryman villages. She is currently the regional manager and is supported by the Ryman clinical support manager. There are two coordinators (one for hospital and one for the rest home) and both are registered nurses. The service coordinator for the serviced apartments is an enrolled nurse. Resident meetings are held in each service area on a two monthly basis and family meetings are held six monthly. Satisfaction surveys are collated annually.

The service has an established quality programme. Quality improvement data is documented through a range of meetings including staff, health and safety and management meetings. There are reports to head office on numbers of incidents and accidents with a qualitative summary documented. The service is benchmarked against like services in Ryman. There is an annual internal audit schedule being implemented and there is a process for managing and monitoring hazards. Incidents are reported.

Improvements are required to the following: the quality and risk management programme, and notification of serious incidents to the DHB and the Ministry of Health.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support. There is a registered nurse/enrolled nurse journal club directed by head office whereby articles, research and questions are discussed. Improvements are required by the service around completion of performance appraisals, attendance at training workshops and to formalise mentoring of new graduates.

Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.

**Continuum of Service Delivery**

Ryman has provided the assistance of a Clinical Support Manager (RN) to assist with the review of care plans and ensure the Ryman systems and processes are in place. 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 utilised for changes in health status, such as wound care and infections. However there is an improvement required to ensure that short term care plans are consistently used for changes in health status. All resident care plans are currently being reviewed to ensure they are personalised. However there continues to be improvements required around aspects of care planning documentation.

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. 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. The service has a large workable kitchen with a menu is designed and reviewed by a registered Dietician, 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**

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. Chemicals are labelled and stored appropriately and there is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. There are improvements required around the management of waste and the management of cleaning.

The service has policies and processes to ensure the consumers' physical environment is managed. Equipment complies with legislation. There is an improvement required around hazard signs for hot water urns. External paved areas are safe for residents and family members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources. There is a call bell system and security systems are in place.

**Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There is currently one resident requiring a restraint and one resident using an enabler. Staff are trained in restraint minimisation and challenging behaviour.

**Infection Prevention and Control**

The infection control coordinator is a facility coordinator and a registered nurse. The service has infection control policies and an infection control manual to guide practice. There is an infection control programme that is reviewed annually. There is an improvement required around infection control training. Infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. There are improvements required around outbreak management, information to residents and family regarding infection issues, facility analysis regarding early intervention or trending, data capture and infection control reporting in staff meetings.

Malvina Major Retirement Village

Ryman Healthcare Ltd

Certification audit - Audit Report

Audit Date: 22-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| **Provider Name** | Ryman Healthcare Ltd |

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| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Malvina Major Retirement Village | 134 Burma Road, | Johnsonville | Wellington |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| **Type of Audit** | Certification audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 22-Aug-13 **End Date:** 23-Aug-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

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| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RN, Auditor Certificate | 16.00 | 8.00 | 22-Aug-13 to 23-Aug-13 |
| Auditor 1 | XXXXXXX | RN, Dip HEd, BSc, Health auditor | 16.00 | 6.00 | 22-Aug-13 to 23-Aug-13 |
| Auditor 2 | XXXXXXX | MBA MN B Ed Adv Dip Child and Family Dip Tchg Lead auditor | 8.00 | 4.00 | 23-Aug-13 |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXX |  |  | 2.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 40.00 | **Total Audit Hours off site** *(system generated)* | 20.00 | **Total Audit Hours** | 60.00 |
| **Staff Records Reviewed** | 13 of 170 | **Client Records Reviewed** *(numeric)* | 11 of 124 | **Number of Client Records Reviewed using Tracer Methodology** | 4of 11 |
| **Staff Interviewed** | 26 of 170 | **Management Interviewed** *(numeric)* | 5 of 5 | **Relatives Interviewed** *(numeric)* | 15 |
| **Consumers Interviewed** | 18 of 124 | **Number of Medication Records Reviewed** | 22 of 124 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 2 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXX (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 Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 26 day of September 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

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|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Malvina Major Retirement Village | 140 | 124 | 60 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Malvina Major is a modern facility that is part of a wider village and is one of Ryman Healthcare villages. The service provides care for up to 120 residents across two floors. Additionally, there are 20 certified serviced apartments. Occupancy is 58 rest home residents including four residents assessed as rest home level care in serviced apartments and 66 hospital residents.

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1.1 Consumer Rights

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Documented systems are in place for essential, emergency and security services. The facility has civil defence equipment. Staff interviews and files evidence current training in relevant areas. There are alternative energy and utility sources. There is a call bell system and security systems are in place.

2 Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There is currently one resident requiring a restraint and one resident using an enabler. Staff are trained in restraint minimisation and challenging behaviour.

3. Infection Prevention and Control

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Summary of Attainment

* 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 | PA Low | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| 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 |

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| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 11 PA Neg: 0 PA Low: 1 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:22 PA:1 UA:0 NA: 0 |

* 1. Organisational Management

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|  |  | **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 | PA Moderate | 0 | 6 | 2 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | PA Low | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Moderate | 0 | 3 | 1 | 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 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 4 PA Neg: 0 PA Low: 1 PA Mod: 2 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:18 PA:4 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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|  |  | **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 | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Moderate | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Moderate | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Low | 0 | 1 | 1 | 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 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 9 PA Neg: 0 PA Low: 1 PA Mod: 2 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:0 FA:18 PA:3 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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|  |  | **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 | PA Low | 0 | 2 | 1 | 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 | PA Low | 0 | 1 | 1 | 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 |

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| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 6 PA Neg: 0 PA Low: 2 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:15 PA:2 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **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 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| 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 |

1. Infection Prevention and Control

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | PA Moderate | 0 | 2 | 1 | 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 | PA Moderate | 0 | 0 | 2 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | PA Moderate | 0 | 1 | 1 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

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| --- |
| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 2 PA Neg: 0 PA Low: 0 PA Mod: 3 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:5 PA:4 UA:0 NA: 0 |

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| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 38 **PA Neg:** 0 **PA Low:** 5 **PA Mod:** 7 **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:** 0 **FA:** 87 **PA:** 14 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Ryman Healthcare Ltd

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:22-Aug-13 End Date: 23-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.3 | 1.1.3.1 | PA  Low | **Finding:**  Resident files in the rest home and hospital were stored in cupboards at the nursing station that had no lock. The residents files stored in the nursing station in the serviced apartments has a lock. During the audit the lock was not locked and the desk was left unattended. On interview the acting manager stated that a corrective action plan was being implemented as soon as the auditors identified these issues. There are four married couples in the facility. Four of eight married couple files did not have information in their files that they were married to someone in the facility or information regarding their need for privacy, time together or preferences.  **Action:**  Ensure residents files are stored in a locked area/cupboard. Ensure married couples have information in their files determining that they have a husband/wife resident in the facility and their privacy needs are reflected in their files. Since the draft report, the service advised that Marital status is documented on the front page of clinical notes | 1 month |
| 1.2.3 | 1.2.3.6 | PA  Moderate | **Finding:**  a) Not all aspects of the quality and risk management programme are linked through the quality system e.g.: three of the five complaints reviewed as part of the audit are not tabled at meetings with evidence of discussion around issues raised and restraint is not a standing agenda item in staff meeting minutes, (though is a standing agenda item at the weekly management meeting). Four pm caregivers interviewed from the hospital did not know that a hospital resident had a restraint. b) While there is a meeting schedule implemented, meeting minutes do not adequately evidence discussion of CQI data. The May 2013 meetings were cancelled because of a norovirus outbreak and staff relied on memo's and emails to receive information. These were infrequently sent. c) There is limited evidence in meeting minutes and through discussion with staff including registered nurses and caregivers that data that is collected and tabled is analysed with action plans/strategies documented to address issues.  **Action:**  Ensure that data is analysed and used to improve service delivery. Ensure that all aspects of service delivery are linked to the quality programme. Ensure restraint is documented as discussed in staff meetings. Ensure all staff are aware of residents who have restraints in the area that they are working. . | 3 months |
| 1.2.3 | 1.2.3.8 | PA  Moderate | **Finding:**  Corrective action plans are not routinely documented e.g. there is no action plan or evidence of resolution of issues raised in the October 2012 satisfaction surveys, resolution of issues raised through the complaints process and no evidence of issues being addressed when raised in the resident/family meetings.  **Action:**  Document corrective action plans when gaps/issues are identified and show evidence of resolution. | 3 months |
| 1.2.4 | 1.2.4.2 | PA  Low | **Finding:**  The MoH and DHB were not notified of the May 2013 norovirus outbreak.  **Action:**  The service is to ensure that the DHB and MoH are notified of serious incidents in a timely manner as these occur. | 6 months |
| 1.2.7 | 1.2.7.5 | PA  Moderate | **Finding:**  i) Three of 13 employee files do not include an annual performance appraisal. ii) 31 of 37 training workshops/sessions show attendance of less than 20 (note there a total of 160 staff). iii) 50% of registered nurses have two or less years’ experience post-graduation, while the journal club is in place a formal mentoring programme is not fully evident  **Action:**  i) Ensure that all employees have an annual performance appraisal. ii) Ensure that staff attend training workshops/sessions . iii) Provide registered nurses who have two or less years' experience post-graduation with a formal mentoring programme. | 3 months |
| 1.3.5 | 1.3.5.2 | PA  Moderate | **Finding:**  (i)Behavioural care plan for one rest home resident documents the distraction techniques that staff can use when the resident is anxious. However the care plan does not identify what behaviours or symptoms the resident displays when anxious. (ii) Progress notes for a rest home resident document a senor mat is put in place beside the residents bed. The use of a sensor mat is not documented in the care plan. (iii) Care plan of a hospital resident reviewed documents that the resident is doubly incontinent. However interventions state the resident is able to manage infrequent episodes of incontinence independently. On discussion with care staff the resident requires assistance with management of incontinence. This has not been updated in the care plan.  **Action:**  Ensure interventions in care plans describe the required support and/or interventions to meet residents needs/goals. | 3 months |
| 1.3.6 | 1.3.6.1 | PA  Moderate | **Finding:**  (i)Progress notes reviewed of two hospital residents documented the residents had had no bowel actions recorded for five and six days prior to nursing intervention being implemented. One of two GPs interviewed during the audit advised that bowel management is an on-going issue and the GP was visiting a resident regarding faecal impaction on day one of the audit. (ii) Care plan reviewed for a hospital resident documents the resident is on daily weight recordings however the medical notes document the GP instructions are that the resident is to be weighed weekly. This was not updated in the care plan or by use of a short term care plan.  **Action:**  (i)Ensure that the interventions documented in care plans relating to the management of constipation are followed and any nursing/medical interventions are implemented in the prescribed timeframes and monitored for effectiveness. (ii) Ensure GP instructions are implemented/followed and updated in care plans. | 1 month |
| 1.3.8 | 1.3.8.3 | PA  Moderate | **Finding:**  (i) A short term care plan was not evidenced completed for a resident re potential for increased falls risk. (ii) a Short term care plan was not completed for a resident re post falls management.  **Action:**  Ensure short term care plans are completed. | immediately- 1 month |
| 1.4.2 | 1.4.2.4 | PA  Low | **Finding:**  Two communal toilets had holes in the ceiling following an electrician working in them between two and three months previously. This was verified by the maintenance person on interview. All plant cupboards had no locks. Hot water urn taps in the rest home and hospital area did not have warning signs to identify 'hot water hazard'.. On interview the acting manager stated that a corrective action on the auditors findings has been initiated around these issues.  **Action:**  Ensure plant cupboards are locked. Ensure hot water boiler taps that can be used by residents/visitors include hazard signs. | 1 month |
| 1.4.6 | 1.4.6.2 | PA  Low | **Finding:**  On the day of audit it was noted that; a) two used linen laundry bags in the hospital were overflowing and the lids would not close properly, b) a laundry trolley lid in a dining area was cracked and damaged, c) black rubbish bags in the facility courtyard skip were overflowing and were spilling out onto the courtyard, d)There was thick dust on the upper surfaces of the entrance chandelier and on the upper surfaces of the fans in the rest home and hospital dining areas, e) the lights in the dining areas had dead fly’s in the glass bowls, f) a rubbish bin lid was on top of dining room cupboards. On interview the regional manager who is acting as the manager and the clinical support manager stated they have initiated a corrective action plan around these issues identified by the auditors (plan viewed)  **Action:**  Ensure laundry /rubbish/high cleaning is managed as per Ryman processes | 3 months |
| 3.1 | 3.1.9 | PA  Moderate | **Finding:**  There is no documented evidence that full outbreak protocol was implemented until the day after the outbreak commenced. The summary of the Norovirus outbreak report states that not until the second day and after the seventh reported case was identified (no times documented) were outbreak warnings issued to visitors and only at this point were staff restricted to working in one area. One person out of 44 residents had a lab test carried out to confirm Norovirus four days after the initial date of outbreak. There is no documentation around Ministry of Health notification of the outbreak (although Public Health were notified). There is no documentation of communication with Massey University regarding their seven student nurses that had been seconded to the facility and had contracted Norovirus  **Action:**  Ensure all staff are aware of timelines regarding initiating Ryman outbreak protocol. Ensure protocol is fully implemented when an outbreak is suspected. Ensure documentation of notifications and communication to student providers is maintained. | 1 month |
| 3.4 | 3.4.1 | PA  Low | **Finding:**  Staff Infection control training was last provided in February 2012. The Ryman in-service training schedule and policy is that infection control training occurs yearly. Twelve currently employed registered nurses working in the facility did not attend the last IC training in February 2013. There is no documentation that the 12 RN's have had an further IC training or updates since this time.  **Action:**  Ensure staff have IC training as determined by Ryman in-service training schedule. Ensure sufficient staff attend training including RN's. | 3 months. |
| 3.4 | 3.4.5 | PA  Low | **Finding:**  There is no documentation of residents and family members training or information sharing during the Norovirus outbreak in May 2013. Resident and relative meeting minutes at the time of the outbreak do not include feedback on infection prevention and control.  **Action:**  Ensure resident and relatives have documented information around infection control issues including outbreaks. | 1 month. |
| 3.5 | 3.5.7 | PA  Moderate | **Finding:**  Infection control statistical trends data is being collated and analysed at head office, however there is no evidence of issues/trend patterns/actions or resolutions being initiated or acted upon at the facility by the IC coordinator prior to the monthly data analysis report summary being received by head office. There is no evidence of early intervention, early reaction or early prevention of possible trends. April and July 2013 trended high in comparison to other months and against other facilities. The infection control summary for the month of the outbreak did not include the seven auxiliary staff members and seven student nurses in the analysis and final statistics. On interview the IC officer stated the Vcare system does include an entry field for non-care staff, however this was not fully completed and therefore the number of staff with Norovirus in the report was not representative of the actual numbers of staff members involved. Staff meeting minutes do not reflect infection control information around specific infections or analysis / trending. Infection control is not a set agenda item in staff meeting minutes (link CAR 1.2.3.6.). There was no IC meeting during the May 2013 outbreak and no post analysis or further corrective actions or education opportunities documented in staff meetings held after the outbreak.  **Action:**  Ensure The IC officer identifies possible infection trends to initiate early interventions. Ensure staff meeting minutes reflect IC information including outbreak information | 1 month |

# Continuous Improvement (CI) Report

Provider Name: Ryman Healthcare Ltd

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:22-Aug-13 End Date: 23-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

**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 Consumer Rights are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and competency questionnaires. Resident rights/advocacy training occurred in August 2013 and 14 staff attended (link CAR 1.2.7.5). Interviews with 14 caregivers (six rest home and eight hospital) established that they understood Code of Rights principles.

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

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

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

On interview 18 residents (ten rest home (including two serviced apartments) and eight hospital) and 15 family members (six rest home and nine hospital), all confirmed that information has been provided around advocacy.

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

**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:**

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

During the visit, staff demonstrated gaining permission prior to entering resident private areas. The service has a policy in place that includes that personal belongings are not used as communal property. Fourteen caregivers (six rest home and eight hospital) interviewed described ensuring privacy by knocking before entering. There is an improvement required around management of resident’s files.

There are currently four married couples resident in the facility. There is an improvement required around information in married couples files.

Values and beliefs information and resident preferences are gathered on admission with family involvement and is integrated with the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with all 14 caregivers identified how they get to know resident values, beliefs and cultural differences.

Interviews with 18 residents (ten rest home (including two serviced apartments) and eight hospital), confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with 14 caregivers (across am, pm and night shifts) described providing choice including what to wear, food choices, how often they want to shower, activities and whether they want to be involved in activities.

There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years. Training last occurred in May 2012. Discussions with 18 residents and 15 family members were positive about the care provided.

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

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

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

**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:** PA **Risk level for PA/UA:** Low

During the visit, staff demonstrated gaining permission prior to entering resident private areas. The service has a policy in place that includes that personal belongings are not used as communal property. Fourteen caregivers (six rest home and eight hospital) interviewed described ensuring privacy by knocking before entering.

There are currently four married couples resident in the facility.

**Finding Statement**

Resident files in the rest home and hospital were stored in cupboards at the nursing station that had no lock. The residents files stored in the nursing station in the serviced apartments has a lock. During the audit the lock was not locked and the desk was left unattended. On interview the acting manager stated that a corrective action plan was being implemented as soon as the auditors identified these issues. There are four married couples in the facility. Four of eight married couple files did not have information in their files that they were married to someone in the facility or information regarding their need for privacy, time together or preferences.

**Corrective Action Required:**

Ensure resident’s files are stored in a locked area/cupboard. Ensure married couples have information in their files determining that they have a husband/wife resident in the facility and their privacy needs are reflected in their files. Since the draft report, the service advised that Marital status is documented on the front page of clinical notes

**Timeframe:**

1 month

**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

There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff receive cultural training. There are two residents in the facility who identify as Maori. There is an established Maori Health plan . The service has developed a link with local iwi.

A3.2 There is a Maori health plan which includes a description of how they will achieve the requirements set out in A3.1 (a) to (e).

D20.1i The service has developed a link with local iwi

The policies for Māori identify the importance of whānau and 14 caregivers (six rest home and eight hospital) and five registered nurses discussed the importance of family involvement. Discussion with 15 family members (six rest home and nine hospital), confirm that they are regularly involved.

**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 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

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

D3.1g The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefs.

D4.1c Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.

**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 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. Five of five registered nurses and all 14 caregivers (six rest home and eight hospital) interviewed were able to describe appropriate boundaries between staff and residents and their families. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.

**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

Comprehensive policy/procedures are established, cross referenced and implementation is supported by way of a thorough and individualised Ryman Accreditation Programme (RAP). This programme includes using some indicators from the standard on safe indicators in aged care and for rest homes/hospitals for falls rate and urinary tract infection targets.

A2.2; D1.3 The service has an acting manager who is supported by the clinical manager and a clinical support manager. They have recognised that there are significant gaps in the service and are working to address these so that services that are provided at Malvina Major. There is an implemented quality improvement programmes that includes performance monitoring. However note improvements required 1.2.3.

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

**Criterion 1.1.8.1 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 🞏 MaI 🞏 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 family including if an incident or care/medical issues arise. Access to interpreter services is identified in the community.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Fifteen family members (six rest home and nine hospital) stated that they are always informed when their family members health status changes.

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

**Criterion 1.1.9.1 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 caregivers identify that consents are sought in the delivery of personal cares and this is confirmed by 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 family members identified that the service actively involves them in decisions that affect their relative’s 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 and relative or nominated advocate is documented on the front page of the resident file.

D4.1d; Discussion with 15 family members (six rest home and nine hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e: All resident files reviewed includes information on residents family/whanau and chosen social networks.

**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; Discussion with15 family members (six rest home and nine hospital) determined that they are encouraged to be involved with the service and care

D3.1.e: Discussion with 14 caregivers (six rest home and eight hospital), five registered nurses and 15 family members (six rest home and nine hospital) and18 residents (ten rest home (including two serviced apartments) and eight hospital), determined that residents are supported and encouraged to remain involved in the community and external groups such as church and RSA.

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights.

A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. This has been updated following this being identified as an area to address in the MoH audit report.

Complaints are documented on VCare. There have been 12 complaints in the hospital and 15 in the rest home in 2013.

Complaints and verbal complaints reviewed for 2012/13 (five written complaints including four in the hospital and one in the rest home) were tracked, indicating that they had been actioned according to timeframes and identified resolution.

The monthly meetings reviewed do not regularly identify discussion of complaints and opportunities for improvement in service delivery (refer 1.2.3).

Residents 18 (ten rest home including (two residents in serviced apartments) and eight hospital and 15 family members (six rest home and nine hospital) state that they would complain if they needed to and all state that they are familiar with the complaints process.

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

**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

Malvina Major is a modern facility that is part of a wider village. It provides rest home and hospital level care for up to 140 residents. Additionally, there are certified serviced apartments. Occupancy is 58 rest home residents including 4 in serviced apartments and 66 hospital residents.

Ryman has robust quality and risk management systems implemented across its facilities that are monitored by head office. To monitor organisation performance, the manager reports weekly to head office and RAP committee meetings occur monthly. The service has policies and procedures and associated implementation systems.

An acting manager has been put in place following a complaint that is currently being addressed. She is the regional manager and has experience as the serviced apartment coordinator, a village manager at Hilda Ross. She is an enrolled nurse with a current practicing certificate and has been at Malvina Major for two weeks. The acting manager has also had experience in setting up a dementia unit and two hospital units with eight years’ experience as manager rest home and one year as a hospital/dementia/rest home manager.

The acting manager is being supported by a clinical support manager (registered nurse) who has also been in the service for two weeks. She has a current APC and has been with Ryman for five years in roles such as clinical manager.

**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

An acting manager (EN) has been put in place following a complaint that is currently being addressed and she is being supported by a clinical support manager (registered nurse) who has also been in the service for two weeks. She has a current APC and has been with Ryman for five years in roles such as clinical manager.

The normal procedures would be for the clinical manager to undertake the role of village manager in the absence of the manager however the acting manager states that because of the complaint and on-going improvements being made to service delivery, there would be a directive from head office around the acting role.

**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:** PA Moderate

Malvina Major has a documented 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.

Quality and risk performance is reported across the facility meetings and also to the organisation's management team.

Discussions with five registered nurses and 14 caregivers (eight hospital and six rest home) and review of meeting minutes demonstrate their involvement in quality and risk activities.

The monthly staff meeting (full facility RAP meeting) included discussing and planning 2013 quality goals for the year.

Resident meetings are held on a two monthly basis in the rest home and in the hospital. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed. The last resident/relative survey was completed in October 2012 with areas identified for improvement in food services, quality of care, call back response and complaints.

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

The service has a quality system that is partially implemented. The service is recording data around incidents, accidents, complaints, internal audits, hazards and risks. Analysis of incident data and infections is being forwarded to head office monthly with qualitative summaries documented. Restraint is discussed at the restraint meeting six monthly. Key staff are attending journal club - meeting minutes sighted for February, April, June 2013.

There are meetings held in the service as follows: monthly RAP Committee meeting, monthly full facility, separate rest home and hospital staff meeting two monthly; nursing journal and peer review two monthly; six monthly restraint; monthly activity meetings; two monthly housekeeping; two monthly kitchen meetings; monthly care staff meetings; two monthly health and safety/IC; weekly management meetings; two monthly resident and six monthly relative meetings. Meeting minutes are documented as per the schedule and record information discussed and tabling of data.

The hazard register is documented with evidence of maintenance issues being addressed and hazards minimised or eliminated

An internal audit schedule is documented and implemented with only three of 36 showing as attaining less than 97%.

There is a documented and implemented document control system.

An improvement is required to the quality plan including the following: staff understanding of the quality and risk management system, all aspects of service delivery are linked to the quality programme, data is analysed and used to improve service delivery and to documentation of corrective action plans with evidence of resolution.

**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:**

**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:** PA **Risk level for PA/UA:** Moderate

The service has a quality system that is partially implemented. The service is recording data around incidents, accidents, complaints, internal audits, hazards and risks. Analysis of incident data and infections is being forwarded to head office monthly with qualitative summaries documented. Restraint is discussed at the restraint meeting six monthly. Key staff are attending journal club - meeting minutes sighted for February, April, June 2013.

There are meetings held in the service as follows: monthly RAP Committee meeting, monthly full facility, separate rest home and hospital staff meeting two monthly; nursing journal and peer review two monthly; six monthly restraint; monthly activity meetings; two monthly housekeeping; two monthly kitchen meetings; monthly care staff meetings; two monthly health and safety; weekly management meetings; two monthly resident and six monthly relative meetings. Meeting minutes are documented as per the schedule and record information discussed and tabling of data.

**Finding Statement**

a) Not all aspects of the quality and risk management programme are linked through the quality system e.g.: three of the five complaints reviewed as part of the audit are not tabled at meetings with evidence of discussion around issues raised and restraint is not a standing agenda item in staff meeting minutes, (though is a standing agenda item at the weekly management meeting). Four pm caregivers interviewed from the hospital did not know that a hospital resident had a restraint. b) While there is a meeting schedule implemented, meeting minutes do not adequately evidence discussion of CQI data. The May 2013 meetings were cancelled because of a norovirus outbreak and staff relied on memo's and emails to receive information. These were infrequently sent. c) There is limited evidence in meeting minutes and through discussion with staff including registered nurses and caregivers that data that is collected and tabled is analysed with action plans/strategies documented to address issues.

**Corrective Action Required:**

Ensure that data is analysed and used to improve service delivery. Ensure that all aspects of service delivery are linked to the quality programme. Ensure restraint is documented as discussed in staff meetings. Ensure all staff are aware of residents who have restraints in the area that they are working. .

**Timeframe:**

3 months

**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:** PA **Risk level for PA/UA:** Moderate

There is evidence of quality improvement plans being initiated through minutes of staff meetings, following internal audits and internal spot audits. Corrective action plans are spasmodically documented.

The resident/relative satisfaction surveys undertaken in October 2012 were issued to the Village in January 2013. However, the village was not required to complete a QIP for the October 2012 surveys, they were expected to complete a narrative informing on discussions with staff on how issues arose and feed back to the RAP Committee at Head Office. Upon review by the Head Office RAP Committee, it was determined to issue a national directive around completion of multi-disciplinary meetings as the majority of concerns raised in the survey were regarding communication. Both the survey, narrative and RAP Committee directive were available during the audit. However, while a narrative is written, how corrective actions were addressed from the issues discussed with staff was not evident.

**Finding Statement**

Corrective action plans are not routinely documented e.g. there is no action plan or evidence of resolution of issues raised in the October 2012 satisfaction surveys, resolution of issues raised through the complaints process and no evidence of issues being addressed when raised in the resident/family meetings.

**Corrective Action Required:**

Document corrective action plans when gaps/issues are identified and show evidence of resolution.

**Timeframe:**

3 months

**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:**

**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:** PA Low

The acting manager and the clinical support manager identify 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 data to the staff and data and qualitative summaries to head office so that improvements can are made (refer 1.2.3). Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the monthly RAP committee meetings, two monthly health and safety meetings and monthly full facility meetings reflect a tabling of incidents/accidents (refer 1.2.3). 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 an indicators from the "Standard on safe indicators in aged care".

A review of incident/accident forms for Malvina Major Identified that ten of ten incident forms are fully completed and included follow-up.

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.

An improvement is required to notification of serious incidents to the DHB and MoH as these occur.

**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:** PA **Risk level for PA/UA:** Low

The acting manager and the clinical support identify 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. Public Health was notified of the May 13 norovirus outbreak.

**Finding Statement**

The MoH and DHB were not notified of the May 2013 norovirus outbreak.

**Corrective Action Required:**

The service is to ensure that the DHB and MoH are notified of serious incidents in a timely manner as these occur.

**Timeframe:**

6 months

**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:** PA Moderate

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

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files were reviewed (the clinical nurse, two coordinators, three registered nurses, maintenance, two kitchen staff, two caregivers, two activities staff). All included their relevant induction books, referee checks and training and development records.

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

There is an implemented education plan 2012 and 2013. The annual training programme well exceeds eight hours annually if each staff member attends. Attendance encouraged at full facility meetings to ensure participation in the Ryman Accreditation Programme. Yearly formal performance review is expected for reflective practice and setting goals including up skilling or other training or qualification goals.

The journal club for registered nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. Interviews with five registered nurses identified that participation in the RN Journal Club is used to advise current practice and provide clinical updates and guidance. New graduates are supported through a robust induction programme including induction module completion, eight week assessment post-employment, ongoing inservice opportunities, RN Journal Club and are supervised by experienced registered nurses, including co-ordinators and the Clinical Manager. Registered Nurses are encouraged to attend external training. Graduate nurses are not left in charge of a shift.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication.

13 of 13 employee files reviewed are well organised.

Residents 18 (ten rest home including (two residents in serviced apartments) and eight hospital and 15 family members (six rest home and nine hospital) state that staff are skilled.

Improvements are required to completion of performance appraisals, new graduate mentoring and attendance at training workshops.

**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:** PA **Risk level for PA/UA:** Moderate

A training plan is documented annually and there is a journal club for registered nurses. Ryman Healthcare ensures RNs are supported through a robust induction programme including induction module completion, 8 week assessment post-employment, ongoing inservice opportunities, RN Journal Club and are supervised by experienced registered nurses. Registered Nurses are encouraged to attend external training. Graduate nurses are not left in charge of a shift.

**Finding Statement**

i) Three of 13 employee files do not include an annual performance appraisal. ii) 31 of 37 training workshops/sessions show attendance of less than 20 (note there a total of 160 staff). iii) 50% of registered nurses have two or less years’ experience post-graduation, while the journal club is in place a formal mentoring programme is not fully evident

**Corrective Action Required:**

i) Ensure that all employees have an annual performance appraisal. ii) Ensure that staff attend training workshops/sessions. iii) Provide registered nurses who have two or less years’ experience post-graduation with a formal mentoring programme.

**Timeframe:**

3 months

**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 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.

Interviews with eight hospital and six rest home caregivers across all shifts, two coordinators (hospital and rest home) and five registered nurses including AM and PM staff indicate that overall the staffing levels are appropriate to meet the needs of the residents.

Residents 18 (ten rest home including (two residents in serviced apartments) and eight hospital and 15 family members (six rest home and nine hospital) interviewed state that there are sufficient staff on duty to meet their needs.

There is a total of 160 staff with 24 hours seven day a week staffing in place. There is a designated registered nurse coordinator for the rest home and one for the hospital.

The acting manager states that there has been a low staff turnover.

The following rosters are implemented:

Hospital (60 residents occupying 60 beds): AM 9 caregivers full shift and one short shift, a fluid assistant three hours and 3 registered nurses. PM: 3 caregivers full shift and 2 from 3.30pm-9pm, 2 registered nurses. Night: 3 caregivers and 1 registered nurse.

Rest home (6 hospital and 54 rest home residents occupying 60 beds): AM 4 caregivers full shift rest home and 4 short shift, 1 registered nurse. PM: 5 caregivers full shift and 2 from 16.30pm-2100, 1 registered nurse, one caregiver 8pm-1am. Night: 3 caregivers and 1 registered nurse.

Serviced apartments (4 at rest home level): AM 3 caregivers (2 full shift and one short shift); PM 1 caregiver 3pm-10pm, one caregiver 4pm-9pm and one 4.30-8.30pm to assist with tea. The registered nurse in the rest home covers the serviced apartments at night.

The village manager and clinical manager are on call as well as the two coordinators and a senior registered nurse.

As of August 2013, there has been a new position created with a caregiver designated to be in the lounge with the residents from 9am-4pm (designed to decrease the number of falls and to help with fluids, toileting etc.

**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 cupboards behind the nurses’ station in all areas. (link to 1.1.3)

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

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

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

There is a Ryman Clinical Support Manager (RN) who has been with the facility for two weeks, assisting and supporting the clinical manager, rest home and hospital coordinators and registered nursing staff to implement the corrective actions required following an unannounced inspection of the facility by the MOH on 30-Jul-13.

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 kept in all three areas 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 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 five rest home ( including two serviced apartment), six hospital). 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.

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 involved with the service and an interview with the GP confirmed he that visits twice weekly or more frequently if needed. A serviced apartment 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) and clinical manager. 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 and wounds 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.

The house GP interviewed stated that coordination of care is good and the hospital and rest home coordinators were always well organised.

Tracer Methodology:

Hospital resident:

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

Rest Home resident:

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

Hospital resident:

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

Rest Home resident

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

**Criterion 1.3.3.1 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:** FA

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. 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 MOH inspection on 30-Jul-13 identified that although assessments were completed they did not link to the care plan. This audit identified that nursing assessment links to the care plan were 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.

**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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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:** PA Moderate

The MOH unannounced inspection which occurred on 30-Jul-13 identified that care plans were generic, repetitive and not personalised. On discussion with the Clinical Support Manager and rest home and hospital coordinator there is a corrective action plan in place (sighted) to review all residents care plans. The service is making progress towards the completion of this goal and six of eleven care plans selected as the sample group were evidenced to have been rewritten and updated within two weeks of the MOH inspection.

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. Eight of eleven files (six hospital, five rest home) reviewed reflected current needs. Therefore there is an improvement required.

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 and dietitians. 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.

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

**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:** PA **Risk level for PA/UA:** Moderate

Eight of elven care plans reviewed described the required support and/or interventions to achieve the desired out comes identified by the on-going assessment process.

**Finding Statement**

(i)Behavioural care plan for one rest home resident documents the distraction techniques that staff can use when the resident is anxious. However the care plan does not identify what behaviours or symptoms the resident displays when anxious. (ii) Progress notes for a rest home resident document a senor mat is put in place beside the residents bed. The use of a sensor mat is not documented in the care plan. (iii) Care plan of a hospital resident reviewed documents that the resident is doubly incontinent. However interventions state the resident is able to manage infrequent episodes of incontinence independently. On discussion with care staff the resident requires assistance with management of incontinence. This has not been updated in the care plan.

**Corrective Action Required:**

Ensure interventions in care plans describe the required support and/or interventions to meet residents needs/goals.

**Timeframe:**

3 months

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

Eleven resident files were reviewed five rest home (includes two serviced apartments) and six hospital.

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 e) resident who sustained a recent fall.

Hospital samples include; a) resident with unintentional weight loss b) resident with a wound, pressure area, c) two residents with challenging behaviours d) resident with restraint, e) resident requiring controlled medication.

There are currently 11 wounds being treated.

Sample of resident files (6) reviewed with current wounds showed a link between short term care planning and wound management plans . Grade II 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.

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

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

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

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Eight of eleven care plans reviewed included interventions consistent with meeting the residents assessed needs. There is an improvement required around interventions for three files.

**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:** PA **Risk level for PA/UA:** Moderate

Eight of eleven care plans reviewed included interventions consistent with meeting the residents assessed needs.

**Finding Statement**

(i)Progress notes reviewed of two hospital residents documented the residents had had no bowel actions recorded for five and six days prior to nursing intervention being implemented. One of two GPs interviewed during the audit advised that bowel management is an on-going issue and the GP was visiting a resident regarding faecal impaction on day one of the audit. (ii) Care plan reviewed for a hospital resident documents the resident is on daily weight recordings however the medical notes document the GP instructions are that the resident is to be weighed weekly. This was not updated in the care plan or by use of a short term care plan.

**Corrective Action Required:**

(i)Ensure that the interventions documented in care plans relating to the management of constipation are followed and any nursing/medical interventions are implemented in the prescribed timeframes and monitored for effectiveness. (ii) Ensure GP instructions are implemented/followed and updated in care plans.

**Timeframe:**

1 month

**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 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

There are four activity coordinators with each coordinator assigned to a specific area (rest home, hospital 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 evaluated and is 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 facility is closely linked to the NZ symphony orchestra and residents receive complimentary tickets to attend concerts and are also able to attend impromptu concerts at the facility by the Wellington Symphony Orchestra musicians.

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.

Residents were also observed to be enjoying music of their choice, on the two mornings of the audit prior to the commencement of the planned activity sessions. Craft work including pictures of spring which residents had created where observed to be displayed in the lounge areas.

Activity coordinators were observed to carry out one on one sessions with residents who prefer not to/or are unable to join in group activities.

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

Eighteen residents (ten rest home (including two serviced apartments) and eight hospital), and 15 family members (six rest home and nine hospital), 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:** FA **Risk level for PA/UA:**

**Finding Statement**

**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 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

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

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. Short term care plans are well utilised. 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 however these were not consistently evidenced completed when there is a change to treatment/care.

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:** PA **Risk level for PA/UA:** Moderate

Short term care plans were evidenced in use for wound care, weight loss and infections. Following the draft report, the provider stated " All medication changes are reflected on medication charts, noted in progress notes, identified on the Health Directives collation sheet in the handover book our policy does not require staff to commence a short-term care plan. Similarly, there is no requirement for staff to complete a short term care plan following a fall, the village uses the Coombes assessment tool, Repeat Falls Analysis (for individual residents), Falls Collation Sheet and, as appropriate a Falls Protocol Response. Falls are further documented in the resident’s progress notes.

**Finding Statement**

(i) A short term care plan was not evidenced completed for a resident re potential for increased falls risk. (ii) a Short term care plan was not completed for a resident re post falls management.

**Corrective Action Required:**

Ensure short term care plans are completed.

**Timeframe:**

immediately- 1 month

**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 manager 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 dementia level care.

One rest home resident has had a recent GP referral completed and sent to the psychogeriatrician.

D 20.1 discussions with the hospital and rest home coordinators, registered nurses identified that the service has access to (but not limited to); physiotherapist, wound care specialist, 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 providers 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. The DHB yellow envelope initiative was evidenced completed. Relatives interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition

**Criterion 1.3.10.2 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:** FA

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by an RN in the hospital, serviced apartment and rest home. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies are on all the drug charts.

Medication administration was observed in the hospital, 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 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. The House GP advised that INR blood tests for those residents on Warfarin are taken on a Tuesday or Friday as required and then he prescribes the warfarin dose as per INR results when he visits on a Monday or Wednesday. Medication fridge’s are monitored weekly in each area.

All senior caregivers/RNs/ENs 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 three monthly for 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.

**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:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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 🗷 MaI 🞏 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 week rolling seasonal menu.

All meals are cooked in the main kitchen which is on the ground floor in the serviced apartments area, and meals are transferred to the rest home and hospital 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.

Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed by ECOLAB. 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 temp audit in January 2013 was 100% compliant.

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 residents 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. On interview 18 residents (ten rest home (including two serviced apartments) and eight hospital) and 15 family members (six rest home and nine hospital) stated residents are happy with the meals provided.

**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 including: general waste, medical waste and sharps. Staff interviewed were aware of practices and processes 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:** PA Low

Ryman have policies and processes that determine legislation and regulatory requirements for local authorities and the MoH. Building maintenance is carried out when identified as necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which expires on 20 November 2013. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2012. Hot water temperatures were sighted and were below 45 degrees.

Health and Safety meetings include maintenance and preventative maintenance.

The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. Hand rails are available around the hall ways. There is an improvement required around unfinished surfaces. There is adequate space around the facility for storage of mobility equipment. There is an improvement required around plant cupboards not being locked and hazard signs for boiler taps in the dining areas . Rest home and hospital residents have access to the front car park area/garden which is level and well maintained.

D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

**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:** PA **Risk level for PA/UA:** Low

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

**Finding Statement**

Two communal toilets had holes in the ceiling following an electrician working in them between two and three months previously. This was verified by the maintenance person on interview. All plant cupboards had no locks. Hot water urn taps in the rest home and hospital area did not have warning signs to identify 'hot water hazard'.. On interview the acting manager stated that a corrective action on the auditors findings has been initiated around these issues.

**Corrective Action Required:**

Ensure plant cupboards are locked. Ensure hot water boiler taps that can be used by residents/visitors include hazard signs.

**Timeframe:**

1 month

**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 have ensuites. Communal toilets are located near the lounges. The service is divided into:- hospital and rest home; and the serviced apartments wing.

**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 wing 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

The rest home and hospital has large lounge areas. There are dining areas attached to lounge areas on each floor. The communal lounge/dining room in the serviced apartments is spacious and allows for a number of different activities.

**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:** PA Low

The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme. Linen service audit for March showed 100% compliance and housekeeping hygiene 93.%. There is an improvement required around high cleaning.

The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are displayed in the cleaning cupboards and there is secure chemical storage areas. The laundry and cleaning areas have hand-washing facilities. There is an improvement required around management of laundry bags, rubbish management,

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

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme. Linen service audit for March showed 100% compliance and housekeeping hygiene 93.%

**Finding Statement**

On the day of audit it was noted that; a) two used linen laundry bags in the hospital were overflowing and the lids would not close properly, b) a laundry trolley lid in a dining area was cracked and damaged, c) black rubbish bags in the facility courtyard skip were overflowing and were spilling out onto the courtyard, d)There was thick dust on the upper surfaces of the entrance chandelier and on the upper surfaces of the fans in the rest home and hospital dining areas, e) the lights in the dining areas had dead fly’s in the glass bowls, f) a rubbish bin lid was on top of dining room cupboards. On interview the regional manager who is acting as the manager and the clinical support manager stated they have initiated a corrective action plan around these issues identified by the auditors (plan viewed)

**Corrective Action Required:**

Ensure laundry /rubbish/high cleaning is managed as per Ryman processes

**Timeframe:**

3 months

**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 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

The Ryman group emergency and disaster manual includes (but not limited to), dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Regular fire drills are completed. Emergencies, first aid and CPR is included in the mandatory in-services programme every two years and the annual training plan includes emergency training. There is someone on duty 24/7 with a current first aid certificate. Last fire drill occurred 31 May 2013. Managing non-clinical emergencies training is carried out.

There is an approved fire service evacuation plan. The service has alternative cooking facilities (gas cooker,) available in the event of a power failure. There are also extra blankets available. There is a civil defence kit. There is water storage available. There is a civil defence folder that includes procedures specific to the facility and organisation.

Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. On interview the Ryman’s operations manager stated that call bell response time are not audited as the call bell system is 15 years old and the system cannot record times. There is a maintenance check to determine if call bells are working. The serviced apartments also include call bells in resident rooms and in ensuites.

The Ryman group has a security checks policy and procedure. The entire facility is secured at night.

D19.6: There are emergency management plans in place to ensure health, 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 thermostatically controlled heating throughout the facility. All rooms have external windows with natural sunlight access. All residents interviewed stated they were happy with the temperature of the facility.

**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 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

There is a Restraint Minimisation Manual 2009 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, included definitions, processes and the use of enablers.

The Restraint Minimisation Manual includes that enablers are voluntary and the least restrictive option. There is one enabler (lap belt) in use in the hospital and one resident requiring restraint (chair support brief) in the hospital. One enabler file was reviewed and included consents and assessments.

**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 facility coordinator and an RN. The coordinator has been in the role for four months. The DHB psychogeriatric nurse specialist is working currently with the restraint coordinator in the capacity to review restraint in the facility. Assessment and approval process for a restraint intervention includes 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 🞏 MaI 🞏 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, currently DHB nurse specialist, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In one resident with restraint file reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family involvement and a specific consent for enabler / restraint form is used to document approval. This was sighted in the one restraint file reviewed.

**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 and approval processes. There is an assessment form/process that is completed for all restraints. The one file reviewed had a completed assessment form and a care plan that reflects risk. A monitoring form that included regular two hourly monitoring (or more frequent) were present in the file reviewed. The one file reviewed has a consent form detailing the reason for restraint and the restraint to be used. In the residents file reviewed an assessment had been completed. A three monthly evaluation of restraint is completed that reviews restraint episodes. The service has a restraint and enablers register for the facility that is up dated 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 evaluation of restraint every month. The restraint process considers the items listed in # 2.4.1. In the one restraint file reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every monthly by the facility restraint co-ordinator and the DHB nurse specialist. A restraint evaluation is completed for each individual month. Evaluation timeframes are determined by risk levels.

**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 six 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 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

There are infection control (IC) policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There are 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 process to report to the IC team on any infection control issues including a reporting and notification to head office policy. There is an infection control officer who is a facility coordinator (RN) who has been in post for one year. The infection control committee is part of the combined H&S/IC committee that meets two monthly.

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. Malvina Major 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.

In May 2013 there was an outbreak of Norovirus. The outbreak lasted from 8 May 2013 until 23 May 2013. Forty-four residents were determined as having contracted Norovirus from throughout the facility, and a total of 27 staff including seven nursing students. There are improvements required around outbreak management.

**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:** PA **Risk level for PA/UA:** Moderate

In May 2013 there was an outbreak of Norovirus. The outbreak lasted from 8 May 2013 until 23 May 2013. Forty-four residents were involved from throughout the facility, and a total of 27 staff including seven nursing students.

The first suspected case was identified on 8 May 2013 with four subsequent suspected cases identified by night staff on the same day. It is documented in the IC officer’s outbreak report written June 2013 that night staff isolated suspected residents however there is no documented evidence that full outbreak protocol was implemented until the next day by the IC officer and the summary report by the IC officer confirms this. On interview the IC officer confirmed that the Summary of the Norovirus outbreak written by him in June 2013 was an accurate report of events. The report also states that not until the second day and after the seventh reported case was identified (no times documented) were outbreak warnings issued to visitors and only at this point were staff restricted to working in one area. One person out of 44 residents had a lab test carried out to confirm Norovirus four days after the initial date of outbreak.

**Finding Statement**

There is no documented evidence that full outbreak protocol was implemented until the day after the outbreak commenced. The summary of the Norovirus outbreak report states that not until the second day and after the seventh reported case was identified (no times documented) were outbreak warnings issued to visitors and only at this point were staff restricted to working in one area. One person out of 44 residents had a lab test carried out to confirm Norovirus four days after the initial date of outbreak. There is no documentation around Ministry of Health notification of the outbreak (although Public Health was notified). There is no documentation of communication with Massey University regarding their seven student nurses that had been seconded to the facility and had contracted Norovirus

**Corrective Action Required:**

Ensure all staff is aware of timelines regarding initiating Ryman outbreak protocol. Ensure protocol is fully implemented when an outbreak is suspected. Ensure documentation of notifications and communication to student providers is maintained.

**Timeframe:**

1 month

**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 🞏 MaI 🞏 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

**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 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

There are infection control policies that supports the Infection Control Standard SNZ HB 8134:2008. There are modified and review dates identified for all infection control policies and procedures. 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 (link CAR 1.4.6.2) re cleaning, 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:** PA Moderate

Infection control training was last provided in February 2012. There is an improvement required around staff training. 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 at the time of the Norovirus outbreak in May 2013 did not 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:** PA **Risk level for PA/UA:** Low

All care staff, including RNs receive full induction including infection control and handwashing training. The RN’s who had not attended recent IC – were they within their first year of employment, if so, they would have completed induction including IC during this time. Infection control training was last provided in February 2012. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.

**Finding Statement**

Staff Infection control training was last provided in February 2012. The Ryman in-service training schedule and policy is that infection control training occurs yearly. Twelve currently employed registered nurses working in the facility did not attend the last IC training in February 2013. There is no documentation that the 12 RN's have had an further IC training or updates since this time.

**Corrective Action Required:**

Ensure staff have IC training as determined by Ryman in-service training schedule. Ensure sufficient staff attend training including RN's.

**Timeframe:**

3 months.

**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:** PA **Risk level for PA/UA:** Low

Resident and relative meeting minutes at the time of the Norovirus outbreak in May 2013 do not include feedback on infection prevention and control.

**Finding Statement**

There is no documentation of residents and family members training or information sharing during the Norovirus outbreak in May 2013. Resident and relative meeting minutes at the time of the outbreak do not include feedback on infection prevention and control.

**Corrective Action Required:**

Ensure resident and relatives have documented information around infection control issues including outbreaks.

**Timeframe:**

1 month.

**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 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

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

The Surveillance policy states the routine/planned surveillance programme is organised and promoted via the RAP calendar. A monthly infection summary report is completed by the IC officer. 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.

Ryman surveillance methods and processes including implementation of an internal audit. 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. There is an improvement required around trends being identified and acted upon by the IC officer. There is an improvement required around the data reported through Vcare.

The IC Officer completes a monthly infection summary and a six monthly comparative summary is completed and forwarded to head office. There is an improvement required around IC being discussed in staff meetings. IC Internal audits are completed and infection data is 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:** PA **Risk level for PA/UA:** Moderate

Ryman surveillance methods and processes including implementation of an internal audit. 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.

The IC Officer completes a monthly infection summary wand a six monthly comparative summary is completed and forwarded to head office. IC Internal audits are completed and Infection data is benchmarked across the organisation

**Finding Statement**

Infection control statistical trends data is being collated and analysed at head office, however there is no evidence of issues/trend patterns/actions or resolutions being initiated or acted upon at the facility by the IC coordinator prior to the monthly data analysis report summary being received by head office. There is no evidence of early intervention, early reaction or early prevention of possible trends. April and July 2013 trended high in comparison to other months and against other facilities. The infection control summary for the month of the outbreak did not include the seven auxiliary staff members and seven student nurses in the analysis and final statistics. On interview the IC officer stated the Vcare system does include an entry field for non-care staff, however this was not fully completed and therefore the number of staff with Norovirus in the report was not representative of the actual numbers of staff members involved. Staff meeting minutes do not reflect infection control information around specific infections or analysis / trending. Infection control is not a set agenda item in staff meeting minutes (link CAR 1.2.3.6.). There was no IC meeting during the May 2013 outbreak and no post analysis or further corrective actions or education opportunities documented in staff meetings held after the outbreak.

**Corrective Action Required:**

Ensure The IC officer identifies possible infection trends to initiate early interventions. Ensure staff meeting minutes reflect IC information including outbreak information

**Timeframe:**

1 month