

Edmund Hillary Retirement Village Limited

CURRENT STATUS: 11-Sep-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

Ryman Edmund Hillary is owned by Ryman Healthcare. The service has capacity for up to 235 residents. The hospital is divided into three separate areas. On the day of the audit there were 185 residents: 80 residents receiving rest home level care including 13 in serviced apartments, 83 residents receiving hospital level care and 22 receiving specialist dementia care. The manager has been at the service for six months and has completed a comprehensive orientation. He is supported by a clinical manager who has been at the service for two weeks and is still undergoing orientation. She has experience as a surgical nurse and one years' experience in aged care.

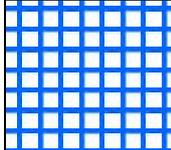
Families, residents and the two general practitioners interviewed spoke positively of the care provided.

This audit has identified improvements required in the following areas: discussion of trends and strategies to manage these, review of the continuous quality improvement plan, notifying the Ministry of Health of increased numbers in the dementia unit, staff appraisals, pain assessments, care plan interventions, evaluation of short term care plans, documentation of as required medication, meeting residents food likes and dislikes, and chemical storage.

AUDIT SUMMARY AS AT 11-SEP-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

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

Consumer Rights	Day of Audit 11-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained

Organisational Management	Day of Audit 11-Sep-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

Continuum of Service Delivery	Day of Audit 11-Sep-13	Assessment
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Safe and Appropriate Environment	Day of Audit 11-Sep-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

Restraint Minimisation and Safe Practice	Day of Audit 11-Sep-13	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained

Infection Prevention and Control	Day of Audit 11-Sep-13	Assessment
Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained

AUDIT RESULTS AS AT 11-SEP-13

Consumer Rights

Edmund Hillary utilises Ryman organisational policies to guide the care provided to residents. 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. Policies are being implemented to support residents' rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time.

Organisational Management

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

The service at Edmund Hillary is led by a village manager who has been in his role for six months. He has a background in senior management roles and is supported by the assistant manager who has been formally in the role for six months, the clinical manager who is a registered nurse and the regional manager who has extensive experience in aged care.

Edmund Hillary is implementing a quality and risk management system with meetings set up to discuss quality improvement data including incidents, accidents, complaints, health and safety and hazards. Internal audits are completed as designated by the programme schedule with evidence of corrective action plans completed with resolution documented. A continuous quality plan for 2013 is documented.

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

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

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are kept in secure areas and there is no information containing personal resident information able to be viewed by other residents or members of the public.

Improvements are required to the quality and risk management programme, to notifying the Ministry of Health about an increase in numbers in the dementia unit and staff appraisals.

Continuum of Service Delivery

There is a needs assessment completed prior to entry to Edmund Hillary. Service delivery plans demonstrate service integration. Assessments and support plans are computerised and identify whom is responsible for the actions. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly. There are improvements required around pain assessments, care planning, interventions provided and evaluation of short term care plans.

There is a comprehensive activities programme at Edmund Hillary. Activities are varied, age appropriate and include inclusion at local community and entertainment events. Independent programmes run in the rest home, the serviced apartments, each of the three hospital units and the dementia unit. Referral to other health and disability services is evident in a sample group of resident files.

The medication management system is appropriate and safely implemented. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents' general practitioner at least three monthly. Individual resident's medication charts were sighted. There is an improvement around documenting indication for use for as required medications.

The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission This is reviewed six monthly as part of the care plan review. Relative and resident meetings are held and meals are discussed. All residents interviewed stated that the food was excellent. There is an improvement required around ensuring likes and dislikes are known by staff serving meals.

Safe and Appropriate Environment

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. 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 is an improvement required around chemical management.

The service has systems in place to manage consumers' physical environment. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. External 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, an appropriate call bell system and security systems are in place.

Restraint Minimisation and Safe Practice

There is a restraint minimisation manual that is applicable to the type and size of the service. The service completes assessments at admission and risks are included in the care plan to minimise the use of restraint/enablers. Assessments are undertaken by suitably qualified and skilled staff in discussion with the family/whanau. The service has seven residents using restraints and six using enablers. There has been a reduction in restraint use since the previous audit. Training has been provided to staff around restraint and challenging behaviours.

Infection Prevention and Control

The infection control coordinator is a hospital coordinator who is 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. Infection control education is provided annually for staff and 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 and reported through to the infection control meeting and the quality and staff meetings. The

infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Edmund Hillary Retirement Village

Edmund Hillary Retirement Village Limited

Certification audit - Audit Report

Audit Date: 11-Sep-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXXX	RcompN, PGDipHSM, Auditor certificate	17.50	10.00	11-Sep-13 to 12-Sep-13
Auditor 1	XXXXXXXXX	RN, BSc, DipHEd, Health Auditor	17.50	7.00	11-Sep-13 to 12-Sep-13
Auditor 2	XXXXXXXXX	RN, Health auditor	17.50	7.00	11-Sep-13 to 12-Sep-13
Auditor 3	XXXXXXXXX	MBA MN B Ed Adv Dip Child and Family Dip Tchg RGON Lead Auditor	8.50	4.00	11-Sep-13 to 12-Sep-13
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXXX			2.00	

Total Audit Hours on site	61.00	Total Audit Hours off site <i>(system generated)</i>	30.00	Total Audit Hours	91.00
Staff Records Reviewed	14 of 180	Client Records Reviewed <i>(numeric)</i>	15 of 185	Number of Client Records Reviewed using Tracer Methodology	3 of 15

Staff Interviewed	39 of 180	Management Interviewed <i>(numeric)</i>	5 of 5	Relatives Interviewed <i>(numeric)</i>	20
Consumers Interviewed	23 of 185	Number of Medication Records Reviewed	29 of 185	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	2

Declaration

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

I confirm that Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 24 day of October 2013

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

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

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

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

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

Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Edmund Hillary Retirement Village	235	185	53	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

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1.1 Consumer Rights

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2 Restraint Minimisation and Safe Practice

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3. Infection Prevention and Control

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Summary of Attainment

1.1 Consumer Rights

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

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

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	2	0	0	0	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	PA Moderate	0	6	2	0	0	9
Standard 1.2.4	Adverse event reporting	PA Low	0	1	1	0	0	4
Standard 1.2.7	Human resource management	PA Low	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

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 4	PA Neg: 0	PA Low: 2	PA Mod: 1	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:0	FA:18	PA:4	UA:0	NA: 0		

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	FA	0	1	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	FA	0	1	0	0	0	2
Standard 1.3.3	Service provision requirements	FA	0	3	0	0	0	6
Standard 1.3.4	Assessment	PA Moderate	0	0	1	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 1.3.12	Medicine management	PA Low	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	PA Low	0	2	1	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 6	PA Neg: 0	PA Low: 3	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 51):	CI:0	FA:15	PA:6	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

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

Safe and Appropriate Environment Standards (of 8):		N/A:0	CI:0	FA: 7	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 36):	CI:0	FA:16	PA:1	UA:0	NA: 0			

2 Restraint Minimisation and Safe Practice

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

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

3 Infection Prevention and Control

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

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

Total Standards (of 50)	N/A: 0	CI: 0	FA: 40	PA Neg: 0	PA Low: 6	PA Mod: 4	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: 90	PA: 11	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Edmund Hillary Retirement Village Limited
 Type of Audit: Certification audit
 Date(s) of Audit Report: Start Date:11-Sep-13 End Date: 12-Sep-13
 DAA: Health and Disability Auditing New Zealand Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.2.3	1.2.3.5	PA Low	<p>Finding: i) There is no documented evidence of discussion of trends and minimal documentation of strategies to manage increases in numbers of incidents or action plans to resolve issues raised as sighted through meeting minutes and from reports. (ii) There is no evidence that complaints or issues/learning arising from complaints are discussed at meetings other than the management meeting on a regular basis.</p> <p>Action: (i) Ensure that there is documented discussion of quality data and actions taken to address issues raised. (ii) Ensure that issues arising from complaints are discussed with explicit links through the quality management system.</p>	3 months
1.2.3	1.2.3.7	PA Low	<p>Finding: There is review of elements of the continuous quality plan sighted through the RAP meeting minutes however robust review of the plan is not documented.</p> <p>Action: Ensure that there is robust documented review of the continuous quality plan.</p>	6 months

1.2.4	1.2.4.2	PA Low	<p>Finding: The service has increased the capacity of the dementia unit on a short term basis by two beds to 22 residents and the MoH has not been informed of this. The DHB have approved this. Since the draft report the provider stated that HealthCERT was notified on 7 May of the proposed increase in capacity .</p> <p>Action: Ensure the MoH is notified of changes in bed capacity.</p>	6 months
1.2.7	1.2.7.5	PA Low	<p>Finding: Three staff files have an annual performance appraisal dated July 2012. Following the audit, the provider advised that all appraisals overdue have been scheduled in September/October and the policy has been corrected.</p> <p>Action: Ensure that all staff have at least an annual performance appraisal.</p>	6 months
1.3.4	1.3.4.2	PA Moderate	<p>Finding: Two of four resident files sampled in the dementia unit have pain noted but no pain assessment (also link 1.3.5.2).</p> <p>Action: Ensure pain assessments are completed for all residents with pain.</p>	3 months

1.3.5	1.3.5.2	PA Moderate	<p>Finding:</p> <p>Two of four files sampled in the dementia unit have issues that have not been addressed in the care plan. One of these care plans has not been updated around pain management following a change of needs identified at care plan evaluation. One resident's behaviour care plan does not include specific behaviour identified in the assessment. Four of six files sampled for rest home residents (two of who are from serviced apartments do not have all current needs identified in the care plan. These are : (i) The falls risk assessment was reviewed in August 2013 and the increased level of risk is not included in the long term care plan. (ii) The evaluation for one resident notes pain which is not included in the long term care plan. (iii) The short term care plan for a resident with a fractured wrist does not include the increase in support required around ADL's and meals. (iv) Auditor advised that resident requires information to be written down due to deafness. This information is not included in the care plan.</p> <p>Action:</p> <p>Ensure all identified needs are addressed in care plans.</p>	3 months
1.3.6	1.3.6.1	PA Moderate	<p>Finding:</p> <p>(i) Supra Pubic Care (SPC): The care plan does not adequately describe the care required including instructions from the Auckland Spinal Unit. The family, resident and a letter from the Auckland spinal unit report that caregivers require training in the management of the suprapubic catheter. The caregivers interviewed could not describe any specific cares for this (other than washing the area in the shower). Training has not been provided in the care of the SPC. (ii) Pressure area risk cares: There are seven residents with pressure areas. Of these seven two do not have appropriate pressure area risk minimisation strategies in the care plan including nutrition and other needs. One care plan simply states ;change of position' with no direction of how frequently. Three of six two hourly turning charts sampled three do not have two hourly turns consistently recorded. (iii) One of five hospital files was for a resident with weight loss that has not been well managed. The resident has lost 10 kg since January 2013 in an on-going and gradual manner. A nutritional assessment was completed in July 2013. The resident was seen by the GP for a regular review in March 2013 and weight loss was noted. When next reviewed for a three monthly review in June 2013 the GP noted weight stable (this was incorrect). The resident has not been referred to a dietitian and continues to lose weight. The RN and caregivers reported that this resident often refuses food and supplementary drinks. (iv) One of four dementia unit files are for residents who has experienced a 4kg weight loss from July to September 2013. The file does not contain the August weight recording for comparison with previous weights. The short term care plan identifies the resident is for a weekly weigh and food and fluid monitoring. These are not occurring. The GP had not been notified. (v) A second dementia resident whose file was sampled has a MNA assessment that identifies them as at risk of malnutrition. The long term care plan states food and fluid monitoring required but this is not occurring. One rest home resident has documented in the care plan evaluation that they require a weekly weight as per GP instruction. This is not</p>	3 months

			<p>included in the care plan (the weekly weighs are occurring). (iv) One of four residents in the dementia unit has recently had frusimide discontinued and the GP documented a specific weight range. There has been a weight gain which has not been identified by staff and the resident is no longer within the specified weight range. There are no blood pressure recordings entered into the resident's file for July and August 2013.</p> <p>Action:</p> <p>(i) Ensure care of the SPC is provided according to best practice guidelines and instructions from the spinal unit and that these cares are documented in the care plan. Ensure that staff are trained in the care and management of the SPC. (ii) Ensure that pressure area prevention measures are included in care plans for residents with pressure areas and that two hourly turns occur when appropriate. (iii) Ensure that residents with weight loss have appropriate referral to dietitian and appropriate monitoring and interventions. (iv) Ensure Doctors instructions are followed and that regular monitoring of recordings occurs.</p>	
1.3.8	1.3.8.2	PA Low	<p>Finding:</p> <p>Three of five hospital files sampled have short term care plans where the issue has resolved but the care plan has not been evaluated.</p> <p>Action:</p> <p>Ensure all short term care plans are evaluated in appropriate timeframes.</p>	3 months
1.3.12	1.3.12.1	PA Low	<p>Finding:</p> <p>One of 29 medication files sampled has prn medication prescribed with no indication for use.</p> <p>Action:</p> <p>Ensure PRN medications document the indication for use.</p>	1 month
1.3.13	1.3.13.2	PA Low	<p>Finding:</p> <p>Caregivers who serve meals in the hospital and rest home do not have information available about residents likes and dislikes when they are serving meals.</p> <p>Action:</p> <p>Ensure caregivers who serve meals in the hospital and rest home are aware of residents likes and dislikes.</p>	6 months
1.4.6	1.4.6.3	PA Low	<p>Finding:</p> <p>(i) One unlocked cupboard in the hospital three wing had cleaning chemicals stored in it. (ii) One bottle of cleaning chemical on a cleaning trolley had no label.</p> <p>Action:</p> <p>(i) Ensure all chemicals are stored in locked cupboards/rooms. (ii) Ensure all chemicals are</p>	3 months.

			appropriately labelled.	
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Continuous Improvement (CI) Report

Provider Name: Edmund Hillary Retirement Village Limited
Type of Audit: Certification audit
Date(s) of Audit Report: Start Date: 11-Sep-13 End Date: 12-Sep-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXXX

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 Mal 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 are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and competency questionnaires. Interviews with 16 caregivers (two rest home, two serviced apartments, 10 hospital and two dementia) and six registered nurses (one rest home, four hospital and one dementia) showed an understanding of the key principles of the code of rights. Resident rights/advocacy/complaints training was provided in 2013 and 85 staff attended.

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 Mal 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 and relatives meetings and the information pack.

Interviews with 23 residents (11 rest home (including three serviced apartments), and 12 hospital), and 20 family members (seven rest home, nine hospital and four dementia), all confirmed that information has been provided around advocacy.

D6,2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The facility provides physical, visual, auditory and personal privacy for residents. During the visit, staff demonstrated gaining permission prior to entering resident rooms. The service has a policy in place that includes that personal belongings are not used as communal property. Sixteen caregivers (two rest home, two serviced apartments, 10 hospital and two dementia) interviewed described ensuring privacy by knocking before entering. This was observed during audit.

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 16 caregivers identified how they get to know resident values, beliefs and cultural differences.

Interviews with 23 residents (11 rest home (including three serviced apartments), and 12 hospital), confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with 16 caregivers (across am and pm shifts) described providing choice including what to wear, food choices, how often they want to shower, activities and whether they want to be involved in activities.

There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years. Abuse and neglect training was delivered in four sessions over 2013 and a total of 85 staff attended. Discussions with 23 of 23 residents (11 rest home (including three serviced apartments), and 12 hospital) and 20 of 20 family members (seven rest home, nine hospital and four dementia) were overall positive about the care provided.

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

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

E4.1a Four of four families from the dementia unit state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.

D4.1a 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: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

D20.1i The service has developed a link with local Maori services. There is one resident who identifies as Maori in the facility. They have cultural information and preferences in their file.

The policies for Māori identify the importance of whānau and 16 caregivers (two rest home, two serviced apartments, 10 hospital and two dementia) and six registered nurses (one rest home, four hospital and one dementia) discussed the importance of family involvement. Discussion with 20 family members (seven rest home, nine hospital and four dementia), 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. Sixteen caregivers (two rest home, two serviced apartments, 10 hospital and two dementia) and six registered nurses (one rest home, four hospital and one dementia), 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
<p>The service has policies to guide practice that align with the health and disability services standards. There is a quality framework and process that is being implemented thorough the Ryman Accreditation Programme (RAP). This programme includes using some indicators from the standard on safe indicators in aged care and for rest homes/hospitals for falls rate and urinary tract infections targets. Staff development occurs by way of education and in-service training. The village manager and the clinical services manager attend training sessions appropriate for their positions.</p> <p>A2.2: Services are provided at Ryman, Edmund Hillary that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.</p> <p>D1.3: All approved service standards are adhered to.</p> <p>D17.7c There are implemented competencies for caregivers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p>	

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:
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Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.9 Communication

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

Full information about the service is provided at entry to residents and family/representatives. On interview all 23 residents and 20 family members interviewed stated that 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 via DHB interpretation services. Some staff were able to described being able to interpret for some residents when needed.

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: Twenty family members (seven rest home, nine hospital and four dementia), 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 16 caregivers (two rest home, two serviced apartments, 10 hospital and two dementia), identify that consents are sought in the delivery of personal cares and this is confirmed by 23 residents (11 rest home (including three serviced apartments), and 12 hospital). Written consent includes the signed admission agreements and medical care guidance plan and care plans acknowledgement document. All 15 resident files (six rest home (including two serviced apartments), five hospital and four dementia), reviewed has signed consent forms. Advanced directives / resuscitation policy is implemented in all 15 resident files reviewed. Resuscitation forms are reviewed annually. Six registered nurses (one rest home, four hospital and one dementia), were able to discuss that residents unable to make a decision are to have resuscitation attempted.

D13.1: There were 15 admission agreements sighted and all 15 had been signed on the day of admission.

D3.1.d : Discussion with 20 of 20 family identified that the service actively involves them in decisions that affect their relatives lives.

Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

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

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

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

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

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

STANDARD 1.1.11 Advocacy And Support

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

D4.1d: Discussion with 20 family members (seven rest home, nine hospital and four dementia), identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e: The resident file includes information on resident’s 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 with all 20 family determined that they are encouraged to be involved with the service and care.

D3.1.e: Discussion with all staff, residents and relatives, determined that residents are supported and encouraged to remain involved in the community and external groups such as church and RSA visits.

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 Mal 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 and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on VCare. Eleven complaints reviewed for 2013 were tracked, indicating that they had been actioned according to timeframes and identified resolution. The management meeting identified discussion of complaints and opportunities for improvement in service delivery (link 1.2.3.6)

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

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

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

Criterion 1.1.13.1 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

Edmund Hillary is a modern facility that is part of a wider village.

Edmund Hillary is one of Ryman healthcare retirement villages. The care centre is modern and spacious. The facility is built across three floors and is designed around a large atrium and courtyards. The service provides dementia unit (special care unit), rest home (including 40 certified serviced apartments) and hospital level care for up to 235 residents. Occupancy is 185 residents (80 rest home residents including 13 in serviced apartments, 83 hospital residents and 22 residents in the dementia unit).

Hospital 1 (43 beds), occupancy, 25 hosp, 18 rest home (43 swing beds)

Hospital 2 (42 beds) occupancy 41 hosp

Hospital 3 (30 beds) occupancy 17 hosp

SCU – (30 beds, 20 certified) occupancy 22 residents, (two extra approved by DHB - link 1.2.4.2)

RH – (50 beds), occupancy 49 rest home (10 swing beds)

SA – 40 certified, occupancy 13 rest home

Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the RAP that includes a schedule across the year for the following areas: a) RAP Head Office, b) general management, c) staff development, d) administration, e) audits/infection control/quality/compliance/health and safety and f) Triple A/activities.

Ryman Healthcare have operations team objectives 2013 that include a number of interventions/actions for ; a) quality system focus forward, b) national dementia project, human resources - recruitment/induction processes, H&S, InterRAI project, and clinical education. The organisation wide objectives are translated at each Ryman service by way of the Ryman Accreditation Programme (RAP) that includes a schedule across the year.

Each service also has their own specific RAP objectives and for Edmund Hillary in 2013 this includes; a) to provide sense of ownership and pride, b) to improve the induction/orientation of new staff, c) to re-focus team on primary nursing, d) to decrease number of pressure areas by 20%, e) to transition the opening of the new hospital unit safely and effectively.

The organisation completes annual planning and has comprehensive policies/procedures to provide rest home care, hospital care and specialist dementia care.

There is a medical component to the certificate and there are currently no residents under this. However, there is a contracted physiotherapist that provides 30 hours a week and two physio assistants five days a week. The manager described a link to a community dietitian if required. There is a contracted medical centre that provides daily services to Edmund Hillary and a clinic is held.

The service has in place a village manager who has a background in horticulture with senior management experience for over 14 years. He has been the village manager for six months and is supported by the clinical manager who has been in the service for two weeks (registered nurse with a current APC) and assistant manager who has been in the role for six months. The facility manager has had a comprehensive orientation to the organisation through head office and through on site visits to other facilities for a two week period. The regional manager states that the assistant manager has informally been in the role for five years noting that this is not documented in the employee file. The assistant manager interviewed is familiar with the policies and procedures and with the assistant manager role. The clinical services manager has recent experience as a surgical nurse and in her last role in a surgical hospital held a safety/quality and risk role. She has one years' experience in aged care three and a half years ago.

The systems manager provides oversight and orientation around the RAP quality programme and she has been with Ryman for 11 years.

Both the systems manager and the regional manager are able to provide support to the village manager when required.

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

ARC,D17.3di (rest home), D17.4b (hospital), The village manager has maintained at least eight hours to date of professional development activities related to managing a village through his orientation.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

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

How is achievement of this standard met or not met?

Attainment: FA

During a temporary absence, the assistant manager undertakes the role of village manager. She has qualifications that are a Dip Marketing, Dip Hospitality and has worked in aged care for seven years including six months as the assistant manager. Her previous roles have been in administration and the assistant manager and the regional manager describe her role as including the assistant manager role although this was in an informal capacity.

The assistant manager would be supported by the regional manager who is a registered nurse with current APC and 14 years' experience in aged care. The regional manager has been in the role since July 2012 and has extensive experience in Australia and New Zealand in clinical and operational management including acute surgical nursing.

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

Criterion 1.2.2.1 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

Ryman has quality and risk management systems implemented across its facilities that are monitored by head office as stated by the systems manager. The systems manager provides oversight of the RAP programme across New Zealand with support as part of the orientation and on-going training programme for staff.

To monitor organisation performance, the manager reports weekly to head office and RAP committee meetings occur monthly. 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.

D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme (RAP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation

and there are clear guidelines and templates for reporting. A review of the RAP programme indicates that there is a review of policies and procedures at head office with these tabled for training and discussion at staff meetings and as part of the training programme.

There is a continuous improvement plan 2013 that identifies key areas of focus including health and safety, primary care nursing, falls and pressure areas, orientation/induction, communication in the facility, quality improvement. Elements of the continuous quality plan are reviewed as sighted through documented RAP meeting minutes however review is not consistently documented regularly throughout the year.

There are comprehensive monthly accident/incident reports that break down the data collected across each area in the facility. Reports are provided from the village manager to head office that includes a collation of incidents/accidents. These are also compared with the previous month, .. There is also an organisational report with graphs completed on a six-monthly basis that benchmarks incidents/accidents across the organisation . Edmund Hillary provides a six monthly comparative summary report that includes recommendations for improvement. Each six months is compared with previous six-month trends.

The monthly manager's report includes complaints/concerns/compliments.

Quality improvement plans are initiated where required.

The hazard identification resolution plan is sent to head office and identifies any key hazards that are identified. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified.

There are a range of meetings that include the following: weekly management meetings, monthly RAP management meetings, two monthly health and safety including infection control, six monthly restraint meetings, monthly registered nurse/enrolled nurse, monthly activities and monthly caregiver meetings. There are also two monthly meetings for each of the following: housekeeping, kitchen staff and maintenance. The meeting minutes show that data is tabled throughout meetings however there is no evidence of discussion of trends, increases in numbers of incidents or action plans to resolve issues raised.

Resident and relative meetings are held throughout the year with minutes indicating that issues are discussed.

Annual resident and relative surveys are completed.

The two monthly journal club (attended by registered/enrolled nurses), directed by head office, reviews the latest clinical practice articles. Topics that have been covered include topics relevant to service delivery.

The internal auditing annual schedule is implemented as per schedule with evidence that any improvements are actioned with resolution documented. If necessary, there are re-audits of the area identified. A facility check is completed by the manager from head office - last in March 2013 and August 2013. The service is working on issues raised from these.

Discussions with six registered nurses (four from the hospital, one from the dementia unit and one relieving in the rest home) and 16 caregivers (10 from the hospital, two from the rest home, two from the dementia unit and two from the serviced apartments) and review of meeting minutes demonstrate their involvement in quality and risk activities.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings that also include review of infection control. A health and safety officer is appointed. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. Ryman has tertiary level ACC WSMP to November 2013. The organisation's benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

D19.2g Falls prevention strategies such as use of sensor mats, increased observation of residents and individual strategies for residents are documented in care plans.

Improvements are required to the following: links through the quality management system around complaints, documented review of the continuous quality plan and discussion of quality data and actions taken to address issues raised.

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: PA

Risk level for PA/UA: Low

There are a range of meetings that include the following: weekly management meetings, monthly RAP management meetings, two monthly health and safety including infection control, six monthly restraint meetings, monthly registered nurse/enrolled nurse, monthly activities and monthly caregiver meetings. There are also two monthly meetings for each of the following: housekeeping, kitchen staff and maintenance. The meeting minutes show that data is tabled throughout meetings however there is no evidence of discussion of trends, increases in numbers of incidents or action plans to resolve issues raised. A review of meeting minutes indicates that incident reporting, infection control, restraint, health and safety are standard agenda items at meetings.

Complaints are an agenda item on the weekly management meeting and on the May 2013 caregiver meeting.

Finding Statement

i) There is no documented evidence of discussion of trends and minimal documentation of strategies to manage increases in numbers of incidents or action plans to resolve issues raised as sighted through meeting minutes and from reports. (ii) There is no evidence that complaints or issues/learning arising from complaints are discussed at meetings other than the management meeting on a regular basis.

Corrective Action Required:

(i) Ensure that there is documented discussion of quality data and actions taken to address issues raised. (ii) Ensure that issues arising from complaints are discussed with explicit links through the quality management system.

Timeframe:

3 months

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

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

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

Audit Evidence	Attainment: PA	Risk level for PA/UA: Low
There is a continuous improvement plan 2013 that identifies key areas of focus including health and safety, primary care nursing, falls and pressure areas, orientation/induction, communication in the facility, quality improvement.		
Finding Statement		
There is review of elements of the continuous quality plan sighted through the RAP meeting minutes however robust review of the plan is not documented.		
Corrective Action Required:		
Ensure that there is robust documented review of the continuous quality plan.		
Timeframe:		
6 months		

Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

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

Corrective Action Required:

Timeframe:

Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

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

The village manager is able to 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 has increased the capacity of the dementia unit on a short term basis by two beds to 22 residents and the MoH has not been informed of this. The DHB have approved this. This is an area requiring improvement.

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made (refer 1.2.3.5). Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. A review of incidents in files reviewed indicates that any falls have a post falls analysis completed and neurological observations are completed when applicable. The data is tabled at meetings held in the facility (refer 1.2.3.5) including minutes of the monthly RAP committee meetings, registered nurse/enrolled nurse meetings, two monthly health and safety meetings and monthly full facility meetings.

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

A review of 20 incident/accident forms for Edmund Hillary identifies that all are fully completed and include follow-up.

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 village manager is able to 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.

Finding Statement

The service has increased the capacity of the dementia unit on a short term basis by two beds to 22 residents and the MoH has not been informed of this. The DHB have approved this. Since the draft report the provider confirmed that "on 7 May notification of proposed increase in capacity was emailed to HealthCERT

Corrective Action Required:

Ensure the MoH is notified of changes in bed capacity.

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 Low

Fourteen of 14 staff files reviewed includes a signed contract, job description relevant to the role the staff member is in, police check, induction, and application form and reference checks.

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. Practicing certificates for other health practitioners are asked to provide evidence of registration as appropriate (for example dietician and podiatrist) and a copy is retained by the facility - sighted all as being current.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Fourteen of 14 staff files were reviewed across a range of levels including registered nurse, kitchen staff, caregivers, housekeeping activities, assistant manager and clinical services manager. All included their relevant induction books, referee checks and training and development records.

Edmund Hillary has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as caregiver, senior caregiver, registered nurse, health and safety 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. Currently any new caregiver is working through completing foundations level 2. There is a specific employees' induction manual. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent. The orientation process includes full induction with all employees and caregiver modules followed by enrolment into the ACE programme to achieve ACE core, ACE advanced and/or ACE dementia, as appropriate, if not achieved prior to employment.

There is an implemented education plan 2012 and 2013. The annual training programme well exceeds eight hours annually noting that there is a low number of staff attending each session. The service has recognised this as an issue and has started offering the same topic in each area following the initial training session. There is an improvement in numbers attending for some sessions and the service continues to work at improving these.

Yearly formal performance reviews in the past have allowed for reflective practice and setting goals including up skilling or other training or qualification goals. Caregivers complete yearly comprehension surveys. Ryman has changed the policy so that staff are offered an annual performance appraisal but do not have to attend. As a result, there are three staff files that have an annual performance appraisal dated July 2012 and the staff member therefore has the choice of

completing an appraisal. Following the audit, the provider advised that all appraisals overdue have been scheduled in September/October and the policy has been corrected.

Registered nurses are supported to maintain their professional competency and there is also a foreign trained nurse development programme. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion.

D17.7d: There are implemented competencies for registered nurses and caregivers related to specialised procedure or treatment including medication competencies and insulin competencies. 10 extra staff files specifically reviewed to ensure that these competencies have been completed annually confirm that these are current.

Interviews with six registered nurses (four from the hospital, one from the dementia unit and one relieving in the rest home) identified that participation in the RN Journal Club is used to advise current practice and provide clinical updates and guidance. (link 1.3.6.1 for Supra pubic catheter training)

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

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

E4.5f There are 20 caregivers who work in the dementia unit. Of these 18 have completed the required dementia standards and two are yet to start. Of those three caregivers that are yet to start, all have commenced employment within the last six months.

There has been an 18% turnover in caregivers and a 21% turnover in registered nurses in the past year. Of the 28 registered nurses, five have been at the service for less than one year (noting that a new hospital unit has opened during this time) and 10 have been at the service between one and two years. Twenty four of the registered nurses are trained in New Zealand and the four trained overseas have completed a CAP course and hold a New Zealand practicing certificate.

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:
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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: Low**

There is an annual training plan (sighted for 2012 and 2013). Training workshops from October 2012 to September 2013 indicate that staff have attended the following: skin integrity, infection control and hand washing, standard precautions, communication, medication management, documentation, gifting, quality and risk, human rights, food on the run, person centred care, continence products, delirium, advocacy and open disclosure, first aid, restraint, civil defence, challenging behaviour, falls prevention, professional boundaries, incident reporting, transportation, promoting independence, safety and security, abuse and neglect, cultural safety, informed consent.

The assistant and regional managers advised that staff turnover has been at 18% for caregivers and 21% for registered nurses over the last year. Seven of 14 staff files include a performance appraisal that has been completed in the last year in August 2012 or later in 2013. Three are new staff and not required to have a current performance appraisal and three have had one last completed in July 2012. The regional manager and the assistant manager advised the auditor that a new policy has been issued by Ryman stating that staff are not required to have a documented performance appraisal.

Finding Statement

Three staff files have an annual performance appraisal dated July 2012. Following the audit, the provider advised that all appraisals overdue have been scheduled in September/October and the policy has been corrected.

Corrective Action Required:

Ensure that all staff has at least an annual performance appraisal.

Timeframe:

6 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

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

The following staff are rostered onto each wing:

Hospital 1 (43 residents of 43 beds): AM - coordinator, two registered nurses, 7 caregivers (four short shifts of six hours). PM - 2 registered nurses, 5 caregivers (including two from 1630-2300 and one from 1600-2100). Night - 1 registered nurse and 2 caregivers.

Hospital 2 (42 residents of 42 beds): AM - coordinator, two registered nurses, 9 caregivers (four short shifts of six hours). PM - 2 registered nurses, 6 caregivers (including two from 1530-2100, 1 from 1600-2300 and one from 1600-2100). Night - 1 registered nurse and 2 caregivers.

Hospital 3 (15 residents of 30 beds): AM - coordinator, one registered nurse, 3 caregivers (one short shift of six hours). PM - 1 registered nurses, 3 caregivers (including one from 1500-2000 and two from 1600-2100). Night - 1 registered nurse and 1 caregiver.

Rest home (49 residents of 50 beds): AM - 1 coordinator, 1 enrolled nurse, 5 caregivers including 1 from 0700-1300. PM - 4 caregivers including 2 from 1600-2100. Night - 2 caregivers.

Dementia unit (22 residents of 21 beds): AM - 1 registered nurse, 2 caregivers. PM - 3 caregivers including 1 from 1600-2000. Night - 2 caregivers.

Serviced apartments (13 rest home residents of 40 beds): AM - 1 coordinator, 4 caregivers including 1 from 0700-1100 and 1 from 0700-1300. PM - 3 caregivers including 1 from 1530-2100 and 1 from 1630-2130. Night - 1 caregivers.

There are 176 staff in the facility including the village manager, clinical manager, assistant manager, hospital/rest home/special care unit/serviced apartments coordinators, wound nurse specialist, 28 registered nurses, 3 enrolled nurses, 82 caregivers, 9 activity staff, 4 gardeners, 5 maintenance, 7 kitchen staff including two chefs and one cook, 12 housekeeping, 8 laundry, 4 administration, 2 night security, 4 servery assistants over meal times.

Staff on the floor on the days of the audit are visible and are attending to call bells in a timely manner.

Interviews with 16 caregivers (10 from the hospital, two from the rest home, two from the dementia unit and two from the serviced apartments) stated that overall the staffing levels are fine and that the manager provides good support.

Twenty three residents interviewed including 12 from the hospital and eleven from the rest home including three from services apartments and 20 family members interviewed including nine from the hospital, four from the dementia unit and seven from the rest home report there is adequate staff numbers.

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 a secure cupboards behind the nurses' station in the nurses' office in all areas.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.

D7.1 Entries are legible, dates and signed by the relevant caregiver or registered nurse/enrolled nurse 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 Ma 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. The village manager screens potential clients for entry to services and requests confirmation of level of care to be received the day prior to admission. Consultation occurs with clinical personnel regarding placement and specific clinical needs. Information gathered at admission is retained in resident's records. There is currently a waiting list for rest home beds and dementia care beds. Potential resident enquiry forms are completed and there are regular follow-up phone calls made (documentation sighted).

Twenty three residents interviewed including 12 from the hospital and eleven from the rest home including three from services apartments interviewed confirmed they received information prior to admission and discussed the admission process with the facility manager.

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

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

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

D14.1 exclusions from the service are included in the admission agreement.

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

E3.1 Four resident files were reviewed and all includes a needs assessment as requiring specialist dementia care.

Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.2 Declining Referral/Entry To Services

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

ARHSS D4.2

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

How is achievement of this standard met or not met?

Attainment: FA

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

Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs. of admission. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy.

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

Wound care folders evidenced in all areas and assessments are signed by a registered nurse. Clinical staff have attended in service and refreshers on clinical care including person centred care, skin integrity, personal hygiene, Liverpool care pathway, first aid and challenging behaviour. Activity assessments and activities care plans have been completed by the activity coordinators.

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

D16.2, 3, 4; Fifteen resident files were reviewed (five from the hospital, four from the dementia unit and six from the rest home including two for residents from serviced apartments). All 15 long term files, the initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe. Care plans developed by the enrolled nurse are countersigned by the RN.

D16.5e; Medical assessments were documented in all 15 long term files within 48 hours of admission. Three monthly medical reviews were documented in 15 of 15 files by general practitioner (link 1.3.6.1). It was noted in 12 of 15 resident files reviewed identified that the GP has assessed the resident as stable and is to be seen three monthly, three files identified a monthly review. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

Assessment tools completed on admission include a) pressure area risk assessment, b) skin integrity, c) continence, d) mobility, e) falls risk, f) cultural assessment and nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

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 that visits daily. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Fifteen files reviewed evidence this is occurring.

The physiotherapist is employed full time and assisted by a physio assistant.

Two GP's interviewed stated that they are notified promptly for any resident concerns. There is an opportunity for the GP's to meet with the families at the three monthly MDT review or earlier if required. The GP's are informed if RN's initiate referrals for nurse specialist input. GP's are responsible for initiating referrals to specialists.

Tracer Methodology hospital:

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

Tracer Methodology: Rest Home resident

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

Tracer Methodology: Dementia care resident

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

Criterion 1.3.3.1 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:
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Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

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

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

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

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, and continence assessment. The nursing care assessment

policy provides guidance in the use of assessment tools. Nutrition needs assessments were also completed on admission. Assessment tools are reviewed and completed six monthly or earlier if there is a change in health status. Two of four resident files sampled in the dementia unit have pain noted but no pain assessment. This is an area requiring improvement. Twenty six staff attended pain management education in 2012 and seven staff in 2013.

An initial support plan is completed within 24 hours. The nursing assessment links to the care plan and this was evident in the 15 long term care plans reviewed. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation.

ARC E4.2; Three of four resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements (see CAR 1.3.5.2).

E4,2a: Challenging behaviours assessments are completed.

Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

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

Finding Statement

Two of four resident files sampled in the dementia unit have pain noted but no pain assessment (also link 1.3.5.2).

Corrective Action Required:

Ensure pain assessments are completed for all residents with pain.

Timeframe:

3 months

STANDARD 1.3.5 Planning

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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

How is achievement of this standard met or not met?

Attainment: PA Moderate

An initial support plan is completed within 24 hours. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and

k) social, spiritual, cultural and sexuality. Interview with six registered nurses and four clinical co-ordinators verified involvement of families in the care planning process. RN's and EN's have attended care planning and documentation and Liverpool care pathway refresher May and August 2013.

Each area of the care plan includes: problems/needs, objectives and interventions. Long term care plans are reviewed at least six monthly or earlier if there are health changes. Seven of 15 resident files sampled did not reflect the resident's current needs. Two of four files sampled in the dementia unit have issues that have not been addressed in the care plan. One of these care plans has not been updated around pain management following a change of needs identified at care plan evaluation. One resident's behaviour care plan does not include specific behaviour identified in the assessment. Four of six files sampled for rest home residents (two of who are from serviced apartments do not have all current needs identified in the care plan. These are :(i) The falls risk assessment was reviewed in August 2013 and the increased level of risk is not included in the long term care plan. (ii) The evaluation for one resident notes pain which is not included in the long term care plan. (iii) The short term care plan for a resident with a fractured wrist does not include the increase in support required around ADL's and meals. (iv) Auditor advised that resident requires information to be written down due to deafness. This information is not included in the care plan. This is an area requiring improvement.

Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as speech language therapist, physiotherapist, podiatrist, dietitians and MHSOP. Resident medications and medical status are reviewed at least three monthly by the General Practitioners. Activity officers maintain activity assessment/care plans and evaluation in residents file. There are specific physiotherapy progress notes and podiatry visits are documented.

E4.3 Two of four resident files reviewed did not identified current abilities, level of independence, identified needs and specific behavioural management strategies. (link 1.3.5.2)

D16.3k, Short term care plans are in use for changes in health status. Examples sighted are as follows: pain, weight gain, rash, bruise, skin tear, reddened sacral area, conjunctivitis, gout and weight loss.

D16.3f; Fifteen resident files reviewed identified that family were involved. Relatives interviewed (nine hospital, four dementia care and seven rest home) confirm they are involved in the care planning process.

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

Each area of the care plan includes: problems/needs, objectives and interventions. Long term care plans are reviewed at least six monthly or earlier if there are health changes.

Finding Statement

Two of four files sampled in the dementia unit have issues that have not been addressed in the care plan. One of these care plans has not been updated around pain management following a change of needs identified at care plan evaluation. One resident's behaviour care plan does not include specific behaviour identified in the assessment. Four of six files sampled for rest home residents (two of who are from serviced apartments do not have all current needs identified in the care plan. These are :(i) The falls risk assessment was reviewed in August 2013 and the increased level of risk is not included in the long term care plan. (ii) The evaluation for one resident notes pain which is not included in the long term care plan. (iii) The short term care plan for a resident with a fractured wrist does not include the increase in support required around ADL's and meals. (iv) Auditor advised that resident requires information to be written down due to deafness. This information is not included in the care plan.

Corrective Action Required:

Ensure all identified needs are addressed in care plans.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

Fifteen resident files were reviewed (six rest home (including two rest home residents in serviced apartments), five hospital and four dementia unit). Residents interviewed (12 hospital, 11 rest home) report their needs are being appropriately met. Relatives interviewed (nine hospital, four dementia care and seven rest home) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. Care plan includes; cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, medication, ADLs, skin, wound and pressure care, pain, dietary/diabetes management, and social, spiritual, cultural and sexuality. Interview with six registered nurses verified involvement of families in the care planning process. Relatives interviewed (nine hospital, four dementia care and seven rest home) confirm they are informed of any changes to their relatives health and interventions required to meet the resident's needs.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and wound management plans/skin tear plans are in place for five skins tears (dementia unit), five wounds and two skin tears (rest home), eight wounds from hospital three including one pressure area, 13 wounds from hospital two including four pressure areas and 12 wounds from hospital one including two pressure areas. Each wound folder has a wound and skin tear register. Evaluations, wound assessments and pain level is carried out at each dressing change. Wound mapping charts and photographs are evident as required. The service has employed a wound specialist and there is evidence of wound specialist input for each wound/skin tear registered. The chronic wound for one rest home resident is linked to the long term care plan. The RN's interviewed (six) also has access to external to wound specialist as

required. Wound care management has been attended by 77 staff to date for 2013. The service employs a wound nurse who works at Edmund Hillary for 18 hours per week. She has 10 years district nursing experience and for the past seven years has worked as a community wound care nurse managing complex wounds for ACC clients. She belongs to the New Zealand wound care society and attended this organisations conference in 2013. She reports that if she required advise or assistance around a wound she would consult with fellow members of the wound care society or the DHB wound nurse specialist. She reviews the wound care folders in each area each week and reviews all pressure areas at least weekly.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the six RN's interviewed. Continence management has been attended by 101 staff to date for 2013.

Weigh chair scales are used to weigh residents monthly. Weight loss short term care plans include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/dietitian notification. There is an improvement required around weight monitoring.

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

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

Long term care plans identify the level of intervention required to meet the identified needs, and goals/objectives in eight of 15 care plans. Seven of the 15 care plans sampled did not reflect the interventions required to meet the objectives/goals for weight management (one hospital, three dementia), pressure area management (two hospital), supra catheter management (one hospital) and clinical assessment for a medical condition (one dementia). This is an area requiring improvement.

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

Fifteen resident files were reviewed (six rest home including two from serviced apartments, five hospital and four dementia unit).

Of the 15 files reviewed, six of those residents were interviewed and all six reported their needs were being appropriately met. Care plan includes; cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, medication, ADLs, skin, wound and pressure care, pain, dietary/diabetes management, and social, spiritual, cultural and sexuality. Care plans were current and family were invited to attend review meetings (correspondence noted in files reviewed). Interview with six registered nurses (four from the hospital, one from the dementia unit and one relieving in the rest home) and four clinical coordinators (three from the hospital and one from the serviced apartments) verified involvement of families in the care planning process.

The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives. There were short term care plans in 14 of the files reviewed.

All files showed a link between short term care planning and wound management plans for residents who have wounds.

D18.3 and 4 Dressing supplies are available and a treatment room is 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.

Finding Statement

(i) Supra Pubic Care (SPC): The care plan does not adequately describe the care required including instructions from the Auckland Spinal Unit. The family, resident and a letter from the Auckland spinal unit report that caregivers require training in the management of the suprapubic catheter. The caregivers interviewed could not describe any specific cares for this (other than washing the area in the shower). Training has not been provided in the care of the SPC. (ii) Pressure area risk cares: There are seven residents with pressure areas. Of these seven two do not have appropriate pressure area risk minimisation strategies in the care plan including nutrition and other needs. One care plan simply states; 'change of position' with no direction of how frequently. Three of six two hourly turning charts sampled three do not have two hourly turns consistently recorded. (iii) One of five hospital files was for a resident with weight loss that has not been well managed. The resident has lost 10 kg since January 2013 in an on-going and gradual manner. A nutritional assessment was completed in July 2013. The resident was seen by the GP for a regular review in March 2013 and weight loss was noted. When next reviewed for a three monthly review in June 2013 the GP noted weight stable (this was incorrect). The resident has not been referred to a dietitian and continues to lose weight. The RN and caregivers report that this resident often refuses food and supplementary drinks. (iv) One of the four dementia unit files reported a resident who has experienced a 4kg weight loss from July to September 2013. The file does not contain the August weight recording for comparison with previous weights. The short term care plan identifies the resident is for a weekly weigh and food and fluid monitoring. These are not occurring. The GP had not been notified. (v) A second dementia resident whose file was sampled has a MNA assessment that identifies them as at risk of malnutrition. The long term care plan states food and fluid monitoring required but this is not occurring. One rest home resident has documented in the care plan evaluation that they require a weekly weight as per GP instruction. This is not included in the care plan (the weekly weighs are occurring). (iv) One of four residents in the dementia unit has recently had frusimide discontinued and the GP documented a specific weight range. There has been a weight gain which has not been identified by staff and the resident is no longer within the specified weight range. There are no blood pressure recordings entered into the resident's file for July and August 2013.

Corrective Action Required:

(i) Ensure care of the SPC is provided according to best practice guidelines and instructions from the spinal unit and that these cares are documented in the care plan. Ensure that staff are training in the care and management of the SPC. (ii) Ensure that pressure area prevention measures are included in care plans for residents with pressure areas and that two hourly turns occur when appropriate. (iii) Ensure that residents with weight loss have appropriate referral to dietitian and appropriate monitoring and interventions. (iv) Ensure Doctors instructions are followed and that regular monitoring of recordings occurs.

Timeframe:

3 months

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are nine activity coordinators who work in individual units. There is an individual programme for each of the three hospital units, the rest home and the dementia unit. The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences', Next of kin input into care and an activities care plan. The care plan includes headings for comfort and wellbeing, outings, interests and family and community (see 1.3.5.2 around the activities plan for one resident in the dementia unit).

This is a comprehensive programme that meets the needs of all consumers. The programme is evaluated and can be individually tailored according to resident's needs.

The activity team described the implementation of the 'Spice of Life', a resident focused programme to enable the village to support residents achieve self-setting goals.

Residents are able to participate in community activities as well as activities in the service itself. In hospital units one and two, the rest home and the dementia unit there are regular van outings. Residents in unit three (which recently opened) have been consulted on two occasions and have opted not to have van outings. When consulted again recently they determined they would now like van outings and these are planned to commence.

The activities programme is developed for a month and a copy of the programme is kept in each resident's bedroom, in and on notice boards thought out the facility.

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

In the dementia cupboard there is a resource cupboard that contains a variety of activities that caregivers and families can access at any time. Caregivers were sighted to take and use balloons from this cupboard during the audit.

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

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

All 23 residents interviewed including 12 from the hospital and eleven from the rest home including three from services apartments and 20 family members interviewed including nine from the hospital, four from the dementia unit and seven from the rest home discussed enjoyment in the programme and the diversity offered to all residents.

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

Criterion 1.3.7.1 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 (sited). Short term care plans are well utilised in the rest home, hospital, and dementia unit. Any changes to the long term care plan are dated and signed. However short term care plans are not always evaluated and this is an area requiring improvement. Fifteen care plans reviewed included handwritten updates to the plan as needs have changed (also link 1.3.6.1).

Short term care plans were sited for (but not limited to) wounds, weight loss, UTIs, poor appetite, gastric infection, UTI and eye infections.

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

ARC: 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: PA

Risk level for PA/UA: 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 (sited). Short term care plans are well utilised in the rest home, hospital, and dementia unit. Any changes to the long term care plan are dated and signed.

Finding Statement

Three of five hospital files sampled have short term care plans where the issue has resolved but the care plan has not been evaluated.

Corrective Action Required:

Ensure all short term care plans are evaluated in appropriate timeframes.

Timeframe:

3 months

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated by the service. The referral is co-ordinated by the clinical leader with input from registered nurses, when the referral is not to a specialist. A letter from the GP is then required.

D16.4c; The service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care.

D 20.1 Discussions with registered nurses identified that the service has access to (but not limited to) dietitians, hospital specialists, speech language therapists, wound care nurse, podiatrist and the physiotherapist.

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 nurse or clinical coordinator and communicated to support new providers. The information meets the individual needs of the transferred resident. The transfer of residents or admission to other provider's policy includes instructions for documentation and whom to notify. One hospital file was reviewed of a resident transferred acutely to hospital identified that a transfer form was completed and family notified. Twenty family members interviewed including nine from the hospital, four from the dementia unit and seven from the rest home, interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition

Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.12 Medicine Management

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

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

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

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

The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. The service uses individualised medication blister packs for regular and PRN medications. The medications are delivered monthly and checked in by the RN on duty and any discrepancies are fed back to the supplying pharmacy. A medication delivery book is maintained. There are pharmacy return bins available. Medications are stored in locked trolleys within locked rooms in each unit. All eye drops in use are dated on opening. Controlled drugs safes are located in the medication rooms for each unit. There are weekly controlled drugs checks sighted in the hospital and rest home controlled drugs register. There are currently no controlled drugs in the dementia unit. The serviced apartments use the hospital controlled drugs safe and medication fridge if required. Medication fridges are monitored weekly (records sighted). There is a list of medication competent RN's and caregivers. All senior caregivers/RNs administering medication complete a medication package. On a six-monthly basis a medication administration competency is completed for each staff member who administers medication. Medication training and competencies last occurred June, July and August and well attended (173 staff). Medication administration observed in the dementia unit met the required standards.

PRN medications have the time of administration on the signing sheet. Controlled drugs are signed by two persons. Standing orders are available. There are no self-medicating residents.

Twenty nine medication charts sampled (four serviced apartments, eight rest home, ten hospital, dementia seven) record prescribed medications by residents' general practitioner, including PRN and short course medications. One PRN medication in the hospital wing did not have an indication for use prescribed. This is an area requiring improvement. All medication charts have photo identification (dated) and allergies/adverse reactions documented. Medications are reviewed three monthly with medical reviews by the attending GP.

D16.5.e.i.2; 29 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: PA****Risk level for PA/UA: Low**

Twenty nine medication charts sampled (four serviced apartments, eight rest home, ten hospital, dementia seven) record prescribed medications by residents' general practitioner, including PRN and short course medications.

Finding Statement

One of 29 medication files sampled has prn medication prescribed with no indication for use.

Corrective Action Required:

Ensure PRN medications document the indication for use.

Timeframe:

1 month

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: PA Low
<p>The kitchen operates from 0630am to 9.30pm daily. There is a morning chef, cook, baker, sandwich maker and dishwasher on each day to prepare and cook the meals. All kitchen staff have completed food safety and hygiene training relevant to their role. On-site chemical safety training is provided Ecolab. The four weekly summer and winter menu is designed and reviewed by a registered dietitian at an organisational level. The menu can be changed in consultation with the dietitian to accommodate resident choice. The chef receives a resident diet requirement for each new admission and changes to residents dietary needs are communicated to the kitchen. Special diets (gluten free, diabetic puddings, vegetarian) and resident likes/dislikes are known by kitchen staff. The chef is notified if the dietitian has been involved in any residents with dietary concerns such as weight loss/gain or swallowing difficulties. Nutritious snacks are available over 24 hours for residents in all units. All meals are cooked in the main kitchen and are transferred to the rest home, hospital and dementia units in insulated containers. Hot food temperature monitoring is taken daily on the midday meal. Trays of food are then removed from the insulated transfer boxes and placed in warmed bain maries. Caregivers who serve meals in the hospital and rest home do not have information available about resident's likes and dislikes when they are serving meals. This is an area requiring improvement. Special diets are name labelled. The dementia unit has individualised menu cards for each resident that includes likes and dislikes. Caregivers in the rest home and hospital units are not aware of the individual likes or dislikes when serving the meals. The caregivers involved in breakfast preparation and serving of meals have attended a safe food handling in-service May 2013.</p> <p>The service has a large workable kitchen that contains a walk-in chiller, double freezer and two single freezers, walk-in pantry, electric oven, two combi ovens and a boiler. The kitchen has a separate dishwashing area, baking, cooking and storage areas. The freezer and chiller temperatures are recorded twice daily. Corrective action is taken when temperatures are outside of the acceptable range (records sighted). All fridges in the kitchenettes are monitored daily. The kitchen equipment is on a planned maintenance schedule. Ecolab provide the chemicals, safety data sheets and chemical safety training as required. Quality control checks are carried out on the dishwasher. The kitchen is locked after hours and the chemicals are stored safely.</p> <p>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.</p> <p>Feedback on the service is received from resident and staff meetings, surveys and audits.</p> <p>E3.3f, There is evidence that there is additional nutritious snacks available over 24 hours.</p> <p>D19.2 Staff have been trained in safe food handling.</p>	

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

Caregivers serve the food from bain maries in kitchenette areas in each unit to the dining room and bedrooms. Special diets are name labelled. The dementia unit has individualised menu cards for each resident that includes likes and dislikes.

Special diets are recorded during and post admission process and they are noted on careplans. Special diets are notified on specific forms with all staff including kitchen made aware of special dietary requirements. This information is kept in a confidential manner in the dining rooms.

Finding Statement

Caregivers who serve meals in the hospital and rest home do not have information available about residents likes and dislikes when they are serving meals.

Corrective Action Required:

Ensure caregivers who serve meals in the hospital and rest home are aware of resident's likes and dislikes.

Timeframe:

6 months

Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**Audit Evidence****Attainment: FA****Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:**

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

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

How is achievement of this standard met or not met?

Attainment: FA

There are implemented policies to guide staff in waste management - Waste Management - general waste, Waste Management - medical, and Waste Management - sharps. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. There is appropriate protective equipment and clothing for staff.

Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

There are policies and processes to guide regarding legislation and regulatory requirements for local authorities and the MoH. Building maintenance is carried out when determined as necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which expires on 13 August 2014. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2013. Health and Safety meetings include maintenance and preventative maintenance.

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

There is an outside area with shade and seating that is observed to be well maintained with paths and handrails.

The dementia unit has 20 beds certified for providing dementia care.

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

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

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

E3.4.c: There is a safe and secure outside area that is easy to access.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

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

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D SI STI MI CI Ma 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. Communal toilets are located near the lounges. The service is divided into three hospital wings, rest home, dementia unit and the serviced apartments.

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 Ma 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. On interview all 23 residents interviewed were happy with their rooms.

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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
Each area has large lounge areas, smaller lounges and family rooms throughout the facility. There are dining areas on each floor. The communal lounge/dining room in the serviced apartments is spacious and allows for a number of different activities. There is a large open plan lounge and dining area in the dementia unit.	
E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.	

Criterion 1.4.5.1 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 Ma 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.

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. The laundry and cleaning areas have hand-washing facilities. Material safety data sheets are displayed in the cleaning cupboards. On interview two cleaning staff stated they had adequate equipment to carry out cleaning management. There is an improvement required around chemical storage and labelling.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Material safety data sheets are displayed in the cleaning cupboards. On interview two cleaning staff stated they had adequate equipment to carry out cleaning management.

Finding Statement

(i) One unlocked cupboard in the hospital three wing had cleaning chemicals stored in it. (ii) One bottle of cleaning chemical on a cleaning trolley had no label.

Corrective Action Required:

(i) Ensure all chemicals are stored in locked cupboards/rooms. (ii) Ensure all chemicals are appropriately labelled.

Timeframe:

3 months.

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 D15.3j; 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. Fire drill and managing non-clinical emergencies training occurs.

The fire service evacuation plan was approved on 2 July 2007. The service has alternative cooking facilities (gas cooker,) available in the event of a power failure. Battery operated emergency lighting is in place. Extra blankets are available. There is a civil defence kit for the whole facility. There is water storage available. There is a civil defence folder that includes procedures specific to the facility and organisation.

Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. Senior caregivers carry a pager and all calls are signalled on a screen with the room number at varied places throughout the facility (this includes serviced apartment rooms). The serviced apartments also have call bells.

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

The entire facility is secured at night. The service utilises security cameras and an intercom system. Visitors book and resident sign out book available. The Ryman group has security checks policy and procedure.

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

Criterion 1.4.7.1 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 central heating throughout the facility. All rooms have external windows with access to natural sunlight.

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 use of enablers.

The restraint minimisation manual includes that enablers are voluntary and the least restrictive option. There are six enablers (all bed rails and in the hospital and rest home areas) in use and seven restraints (two geriatric tables and five bed rails, all in the hospital). Three enabler files were reviewed and included consents and assessments.

E4.4a The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

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 the hospital three clinical coordinator who is an RN experienced in aged care. 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, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In three files 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. These were sighted in the three restraint files 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
<p>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 three files reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the three files reviewed. Three files reviewed have a consent form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms had been completed. Assessments are completed. A three monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is up dated each month.</p>	

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 three restraint files reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every monthly by the facility restraint co-ordinator and RAP meeting. A restraint evaluation is completed for each individual month. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner.

Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;

- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

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

Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

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

STANDARD 2.2.5 Restraint Monitoring and Quality Review

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

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There is policies including (but not limited to); a) a scope and application of the NZ standard for IC policy, b) infection control management policy, c) infection control governance policy, and d) defined and documented IC programme policy. There are clear lines of accountability to report to the infection control (IC), team on any infection control issues including a ' reporting and notification to head office policy. There is an IC responsibility policy that includes chain of responsibility and an IC officer job description. The defined and documented IC programme policy states that the IC programme is set out annually from head office and is directed via the Ryman Accreditation Programmes annual calendar.</p> <p>The annual review policy states IC is an agenda item on the two monthly head office H&S committee. Ryman, Edmund Hillary also undertakes a six monthly comparative summary report on all infections that is reported to staff.</p> <p>The service infection control manual includes a policy on a) admission of resident with potential or actual infections policy, b) infectious hazards to staff policy, c) outbreak management d) staff health policy and e) isolation policy. The IC officer could describe how they would manage an outbreak and there are individual policies such as scabies management policy. There have been no outbreaks since the previous audit.</p>	

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:
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Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?

Attainment: FA

The infection control officer could describe access to infection control specialist through the DHB. Ryman's management team and GP input into infection control is available when required. The IC officer is one of the hospital coordinators who is a registered nurse. She has been in the role for one month. She has worked as an IC coordinator in another aged care facility. The IC officer has undertaken Ministry of Health IC training.

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

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

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

Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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

STANDARD 3.4 Education

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

ARC D5.4e ARHSS D5.4e

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

How is achievement of this standard met or not met?	Attainment: FA
Infection control training is provided by the infection control officer and several training sessions are provided annually. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. Resident and relative meeting minutes include feedback on infection prevention and control.	

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

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

Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

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

STANDARD 3.5 Surveillance

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

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

How is achievement of this standard met or not met?	Attainment: FA
<p>The Surveillance policy states the routine/planned surveillance programme is organised and promoted via the RAP calendar. The IC/H&S committee meet monthly and also act as the IC committee. A monthly infection summary report is completed. The surveillance includes a) systematic surveillance, b) response to surveillance activities, c) development of the surveillance programme, d) standardised definitions, e) surveillance methods, f) reports and g) assessment of effectiveness of surveillance.</p> <p>Surveillance methods and processes including implementation of an internal audit are appropriate for the size and service level cares provided at this facility. All infections are collected via the 'infection report form' and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report of generated. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.</p> <p>The IC officer then completes a monthly infection summary which is discussed at bimonthly H&S/IC meetings and a six monthly comparative summary is completed and forwarded to head office. All meetings held at Edmund Hillary include discussion on infection control (minutes viewed). Internal audits are completed. Infections are benchmarked across the organisation.</p>	

Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe: