**Yvette Williams Retirement Village Limited**

**Current Status:** **03-Oct-13**

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

**General overview**

Yvette Williams Retirement Village opened in March 2011. The Village is certified for 60 hospital residents; 30 Resthome residents in the serviced apartments, and 30 residents for specialist hospital (psychogeriatric) care. On the day of the audit there were 57 hospital residents, three rest home residents (including two rest home residents in the serviced apartments), and 28 residents receiving specialist hospital (psychogeriatric) care.

Ryman Healthcare has an organisational total quality management plan and key operations quality initiatives that are implemented at Yvette Williams Retirement Village.

The village manager, who is newly appointed to the service (August 2013) has a background in finance and management. She is supported by an experienced aged care clinical manager and regional manager. The regional manager and village manager report staff turnover is low. On-going clinical support and training is regularly provided to qualified staff through meetings, training sessions, competencies and journal club. Three shortfalls from the previous audit in relation to restraint assessments, short term care plans and infection control nurse training have all been addressed. There are no shortfalls identified at this audit.

**Audit Summary AS AT** **03-Oct-13**

Standards have been assessed and summarised below:

**Key**

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

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| --- | --- | --- |
| **Consumer Rights** | Day of Audit  03-Oct-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** |

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| **Organisational Management** | Day of Audit  03-Oct-13 | Assessment |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | **Standards applicable to this service fully attained** |

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| **Continuum of Service Delivery** | Day of Audit  03-Oct-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. |  | **Standards applicable to this service fully attained** |

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| **Safe and Appropriate Environment** | Day of Audit  03-Oct-13 | Assessment |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | **Standards applicable to this service fully attained** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  03-Oct-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Standards applicable to this service fully attained** |

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| **Infection Prevention and Control** | Day of Audit  03-Oct-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** |

**Yvette Williams Retirement Village**

Yvette Williams Retirement Village Limited

Surveillance audit - Audit Report

Audit Date: 03-Oct-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Yvette Williams Retirement Village Limited |

|  |  |  |  |
| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Yvette Williams Retirement Village | 383 Highgate | Roslyn | Dunedin |

|  |
| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
|  |

|  |  |
| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) |
| **Date(s) of Audit** | **Start Date:** 03-Oct-13 **End Date:** 04-Oct-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXXX | R N, Lead auditor | 12.00 | 6.00 | 03-Oct-13 to 04-Oct-13 |
| Auditor 1 | XXXXXXXX | MHA, Dip Phys, RABQSA Lead auditor | 12.00 | 4.00 | 03-Oct-13 to 04-Oct-13 |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXXX |  |  | 1.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 24.00 | **Total Audit Hours off site** *(system generated)* | 11.00 | **Total Audit Hours** | 35.00 |
| **Staff Records Reviewed** | 7 of 122 | **Client Records Reviewed** *(numeric)* | 8 of 88 | **Number of Client Records Reviewed using Tracer Methodology** | 3of 8 |
| **Staff Interviewed** | 12 of 122 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 6 |
| **Consumers Interviewed** | 10 of 88 | **Number of Medication Records Reviewed** | 18 of 88 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

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

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

Dated this 4 day of November 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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Yvette Williams Retirement Village | 90 | 88 | 60 | 🞏 | 🗷 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Executive Summary of Audit

General Overview

Yvette Williams Retirement Village opened in March 2011. The Village is certified for 60 hospital residents; 30 Resthome residents in the serviced apartments, and 30 residents for specialist hospital (psychogeriatric D6) care. On the day of the audit there were 57 hospital residents, three rest home residents (including two rest home residents in the serviced apartments), and 28 residents receiving specialist hospital (psychogeriatric) care.

Ryman Healthcare has an organisational total quality management plan and key operations quality initiatives that are implemented at Yvette Williams Retirement Village.

The village manager, who is newly appointed to the service (August 2013) has a background in finance and management. She is supported by an experienced aged care clinical manager and regional manager. The regional manager and village manager report staff turnover is low. On-going clinical support and training is regularly provided to qualified staff through meetings, training sessions, competencies and journal club. Three shortfalls from the previous audit in relation to restraint assessments, short term care plans and infection control nurse training have all been addressed. There are no shortfalls identified at this audit.

1.1 Consumer Rights

Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care.

The service has a robust complaints process in place that aligns with the Code of Health and Services Consumers' Rights and links to the organisation's quality and risk management system.

1.2 Organisational Management

The service continues to implement a comprehensive quality system that evidences on-going quality initiatives. The RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six month period. Resident meetings are held on a two monthly basis in each area. Relative meetings are held six monthly. Annual resident and relative surveys are completed. The service continues to collect data to support the implementation of corrective action plans. The internal auditing annual schedule is implemented as per schedule.

Yvette Williams Retirement Village has a comprehensive orientation/induction programme in place that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as(but not limited to) caregiver, senior caregiver, registered nurse, health and safety representative, and clinical manager. The orientation/induction training for caregivers, on completion, provides them with a level two national certificate in support of the older person. There is an implemented education plan for 2013. The annual training programme exceeds eight hours annually. Staff education and training includes the aged care education (ACE) programme for caregivers. Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. A recent recruitment drive has been in place to fill gaps in the roster. A hospital coordinator position is in the process of being filled.

1.3 Continuum of Service Delivery

Service delivery plans demonstrate service integration. Registered nurses are responsible for assessment, care planning and evaluation. Residents and families are involved in planning care and providing feedback. Contractual timeframes are met around long term care plans. Continuity of service is managed by verbal handover at the end of each shift and through progress notes. Risk assessment tools and monitoring forms are available and implemented to assess level of risk. Short term care plans are in place for acute changes in care including wound management. A previously identified shortfall in regard to the linkage between wound care management and short term care plans is now being met. Residents and relatives spoke positively about the care and support provided. The service activities programme supports resident’s activity and is able to meet the needs of residents. Activity programmes were sighted in all three areas including group activities and one-on-one activities. The service is commended for the implementation of their overall activity programme and initiatives to meet the individual needs of the residents. The service uses individualised medication blister packs. Staff administering medication complete six monthly competencies.

The service has a large workable kitchen with a menu is designed and reviewed by a registered dietitian. Staff at the facility have completed food safety training. Two monthly resident meetings are held and meals are discussed. Residents stated the food was very good. There are regular audits of the kitchen, regular fridge/freezer temperatures and food temperatures are undertaken.

1.4 Safe and Appropriate Environment

The building holds a current warrant of fitness which is posted in a visible location and expires on 14 October 2013.

2 Restraint Minimisation and Safe Practice

There is a Restraint Minimisation Manual 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. Where a new type of restraint had been added, a full assessment is documented for the additional restraint. This previously identified shortfall is now being met.

3. Infection Prevention and Control

All infections are collected via the ' infection report form' and all collected and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report of generated. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.

The IC Officer then completes a monthly infection summary which is discussed at bimonthly H&S/IC meetings and a six monthly comparative summary is completed and forwarded to head office. All meetings held at Yvette Williams Retirement Village includes discussion on infection control. Internal audits are completed. Infections are benchmarked across the organisation. The IC officer has completed external education, a previous shortfall which is now being met.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 2 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:4 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 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 34): CI:0 FA:17 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | FA | 0 | 3 | 0 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 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 51): CI:0 FA:14 PA:0 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | FA | 0 | 1 | 0 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:1 PA:0 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 4 CI:0 FA: 2 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:2 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

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

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| **Total Standards (of 50) N/A:** 32 **CI:** 0 **FA:** 18 **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  **Total Criteria (of 219) CI:** 0 **FA:** 41 **PA:** 0 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Yvette Williams Retirement Village Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:03-Oct-13 End Date: 04-Oct-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

# Continuous Improvement (CI) Report

Provider Name: Yvette Williams Retirement Village Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date:03-Oct-13 End Date: 04-Oct-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 1.1.9 Communication**

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

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

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

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

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

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

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

D16.4b Six relatives stated that they are always informed when their family members health status changes.

ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to dementia unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident’s handbook providing practical information for residents and their families.

'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 1.1.13 Complaints Management**

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

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

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

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on VCare. Complaints and verbal complaints reviewed for 2012/13 (13 year-to-date) were tracked, indicating that they had been actioned according to timeframes and identified resolution. The monthly staff meeting minutes and interviews with staff confirm discussion of complaints and opportunities for improvement in service delivery take place during staff meetings.

One complaint, lodged through the DHB (July 2013), relates to a perceived lack of available staff for the provision of care. A full investigation prompted a Quality Improvement Plan (QIP) to address staffing levels. Actions taken have included filling gaps in the roster with four additional caregivers, adding another full-time RN to the service (currently in process) and improving weekend staffing. Appropriate communication with the family was evidenced in the complaints management documentation with the family reporting 'noticeable improvements'.

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

ARHSS D13.3g: The complaints procedure is provided to relatives on admission.

**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

Yvette Williams Retirement Village is a modern facility that is part of a wider village. It provides rest home, hospital and specialised hospital (psycho-geriatric) level care for up to 90 residents. In addition, there are 32 certified rest home level serviced apartments. Occupancy is three rest home residents in the hospital, fifty-seven hospital residents, twenty-eight psychogeriatric residents and two rest home residents in the serviced apartments.

Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. To monitor organisation performance, the manager reports weekly to head office and RAP committee meetings occur monthly. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme (RAP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation and there are clear guidelines and templates for reporting.

The village manager, who is newly appointed to the service (August 2013) has a background in finance and management. She is supported by an experienced clinical manager and regional manager. Care staff (five caregivers, three RNs, two diversional therapists) report they feel supported by the management team.

ARC E2.1, ARHSS D5.1 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), ARHSS D17.5 The regional manager and clinical manager maintain a minimum of eight hours of professional development relating to the management of a hospital. Plans are in place to ensure the newly appointed village manager also maintains a minimum of eight hours annually of professional development activities relating to the management of an aged care facility. This will include (but is not limited to) a three-day Ryman Healthcare conference.

**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 1.2.3 Quality And Risk Management Systems**

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

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

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

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

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

Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with three registered nurses and five caregivers and review of meeting minutes demonstrate their involvement in quality and risk activities. The monthly staff meeting (full facility RAP meeting) includes discussions and planning relating to the 2013 quality goals for the year.

Resident meetings are held on a monthly basis. Relative meetings are held six-monthly. Minutes are maintained. Annual resident and relative surveys are completed. Annual resident satisfaction surveys and relative satisfaction surveys are undertaken with evidence of quality improvement plans where opportunities for improvement are identified.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. The Management Resource Manual 2009 has been updated to align with the revised NZS 8134:2008.; The RAP programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar.

There are adequate clinical policies and procedures for rest home, hospital and psychogeriatric level care. The monthly journal club (attended by registered/enrolled nurses), directed by head office, reviews the latest clinical practice articles. Topics that have been covered include (but are not limited to): professional development; Norovirus; warfarin use; pressure area prevention; enduring power of attorney/advance directives; care planning; palliative care; syringe drivers.

There are policies and tools for the following:

a) Continence management and a continence assessment tool. Continence assessment tools were present in all eight residents' files reviewed, including one rest home level from the serviced apartments.

b) Pain management policy and a pain assessment tool. Care plans identified interventions to manage pain.

c) Personal grooming and hygiene policy.

d) Skin integrity management policy and a pressure risk assessment tool.

e) Wound care policy and procedures and a wound assessment/management plan.

Wound assessment and wound management plans are in place. Wound care plans were noted to be comprehensive and well documented (reference 1.3.6.)

f) Transportation of subsidised residents policy and procedure includes costs, resident and staff safety. The facility has a van for residents' outings. Staff who drive this vehicle have their driver's license checked and hold a current first aid certificate.

g) D10.1 Death policy and procedure. The policy outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.

h) Challenging behaviour policy and a behaviour monitoring form that includes behaviour observation charts to record events and then evaluate findings in order to determine management techniques.

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

There is a comprehensive quality and risk management process in place. The service monitoring programme includes (but is not limited to); infection control, quality improvement, health and safety, service delivery, resident rights, managing service delivery, emergency and human resources. Monitoring in each area is completed monthly, six monthly or annually as designated by the RAP programme schedule. This is monitored and reviewed through reporting to head office. A monthly incident/accident and infection analysis is forwarded to head office.

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

The service continues to collect data to support the implementation of corrective action plans. The internal auditing annual schedule is implemented as per schedule.

Meetings are minuted including actions to resolve areas identified for improvement and quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement.

Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. A health and safety officer is appointed.

Risk management, hazard control and emergency policies and procedures are in place.

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

Hazard identification and control occurs and hazards register in place. On-going hazards are identified through health and safety meetings.

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.

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

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

D19.2g Falls prevention strategies such as electronic lighting and sensor monitors in each of the residents' rooms are in place to minimise the risk of falls.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

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

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

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

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

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

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the monthly RAP committee meetings, two monthly health and safety meetings and monthly full facility meetings reflect a discussion of incidents/accidents and actions taken. A six monthly comparative analysis is completed of incidents for internal benchmarking across Ryman's facilities. In addition, each facility receives an analysis of the last three six monthly periods from which to identify trends and improvements. Falls rates are compared to an indicators from the "Standard on safe indicators in aged care".

A review of incident/accident forms for Yvette Williams Retirement Village identified that 12 of 12 incident forms were fully completed and included follow-up. In each instance, there was documented evidence of families being informed. Interviews with six families (four with relatives in the hospital and two with relatives in the psychogeriatric unit) confirm that they are kept informed.

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

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.7 Human Resource Management**

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

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

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

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

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

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were randomly selected for review (four registered nurses, two caregivers, one enrolled nurse). All included their relevant induction books, referee checks and training and development records.

Yvette Williams Retirement Village has a comprehensive orientation/induction programme in place that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as (but not limited to) caregiver, senior caregiver, registered nurse, health and safety representative, and clinical manager. 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 is monitored by the organisation. There is a specific employees' induction manual. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent.

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

There is an implemented education plan for 2013. The annual training programme exceeds eight hours annually. Staff education and training includes the aged care education (ACE) programme for caregivers. On-going training via the in-service programme is in place to meet MOH guidelines and any ad hoc training specific to the Village or residents' needs. Attendance is encouraged at full facility meetings to ensure participation in the Ryman Accreditation Programme (evidenced in interviews with five caregivers, two diversional therapists and three RNs). Yearly formal performance reviews are in place for reflective practice and setting goals including up skilling or other training or qualification goals. Caregivers complete yearly comprehension surveys (evidenced in two caregiver HR files).

Registered nurses are supported to maintain their professional competency. A foreign trained nurse development programme is in place. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. Interviews with three registered nurses identified that participation in the RN Journal Club is used to advise current practice and provide clinical updates and guidance. Yearly formal performance reviews specific to RNs for reflective practice and setting goals includes up skilling or other training or qualification goals.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication comprehension, medication administration, clinical competence.

ARHSS D17.7 The diversional therapist working in the special care unit has completed the ACE dementia modules.

ARHSS D17.1: There are 17 caregivers in the psychogeriatric unit. Twelve caregivers have completed the required dementia standards and five staff, employed less than one year on the psychogeriatric unit, are in the process of completing theirs.

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

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

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

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

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

The regional manager and village manager report staff turnover is low. A recent recruitment drive has been in place to fill gaps in the roster (reference 1.1.13). Interviews with five caregivers across the three service lines (hospital, psychogeriatric, rest home) report that overall the staffing levels are adequate and that the registered nurses and clinical manager (psychogeriatric unit) provide good support. An RN position (hospital coordinator) for the hospital/rest home is in the process of being filled.

Six relatives (four with family in the hospital and two with family in the psychogeriatric unit) report that staffing levels are appropriate to meet the needs of their family.

**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:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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

**STANDARD 1.3.3 Service Provision Requirements**

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

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

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

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

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

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

Wound care folders (four) evidenced in all areas, included assessments and evaluation of wound care which is completed by the registered nurses.

Activity assessments and activities care plans have been completed by the activity therapists.

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

D16.2, 3, 4; An assessment and initial care plan is completed within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. All eight resident files were reviewed (two hospital, two rest home, three psychogeriatric and one service apartment resident receiving rest home care). All eight long term files the initial admission assessment and care plans were completed on admission and long term care plans were completed by the registered nurses within a three week timeframe.

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

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.

ARHSS D16.6; Three residents with behaviours that challenge were reviewed from the psychogeriatric unit. Behaviours in all three files were well identified through the assessment process, management plans implemented, short term care plans were developed for acute episodes of challenging behaviour with evidence of regular evaluations.

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 weekly and as required. An experienced service coordinator is responsible for residents in the services apartments. Progress notes are maintained. Progress notes are written on every shift. All eight files reviewed evidence this is occurring. A weekly management meeting provides an opportunity to discuss any clinical issues.

The service has a Physiotherapist employed for six hours -three days a week and a physio assistant provides physio support 25 hours a week as directed by the physio.

GP interviewed stated that the registered nurses called him in a timely fashion, supplying him with observations appropriate for him to assist the assessment of the resident and the registered nurses completed follow up as requested and kept GP informed of changes.

Tracer Methodology:

Rest Home (in serviced apartment):

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

Hospital Care:

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

Specialised Hospital (psychogeriatric) care:

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

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

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

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

Eight resident files were reviewed (two rest home, two hospital and three psychogeriatric unit. One resident file from the service apartments receiving rest home care was also reviewed).

Rest home files (three) included: Resident with pain and recent transfer to hospital; resident with weight loss; and resident with chest infection and transfer to hospital.

Hospital files( two) included: Resident who is a frequent faller and has experienced weight loss and a resident with pain requiring controlled drugs for pain.

Psychogeriatric Unit files (three) included: resident who was a frequent faller, utilizing restraint, pressure area and weight loss; resident requiring controlled drugs for pain, wounds and restraint; and resident with challenging behaviour, utilizing restraint and has a wound.

Of the eight files reviewed, five of those residents were interviewed and all five 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 three registered nurses 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 all eight of the files reviewed.

Six of the eight files reviewed had wound documentation and all six files showed a link between short term care planning and wound management plans. Wound assessment and wound management plans are in place for 11 residents in psychogeriatric unit and for 18 residents in the hospital/rest home unit. There is a wound and skin tear register with wound description/treatment plans and evaluations of wound. This is an improvement from the previous audit.(1.3.6.4)

On 4/9/13 the service completed a review of wound care assessments with seven wounds identified as pressure related. The service instigated a QIP in regards to wound care. External input was received from the General practitioner, wound care specialists and dietitian. Nutritional assessments were completed for all residents with a wound, with supplements prescribed as required; manual handling in service was provided by physiotherapist in view of preventing shearing/friction wounds from occurring; pressure injury prevention in services provided 11/9/13; pressure area care was discussed at all staff handovers; Ryman wound specialist nurse completed a review of wound documentation with care plans updated to reflect appropriate intervention and provided wound care education to registered nurses 13/9/13; attendance by four registered nurses at a study day at DPH-28/9/13; the need for pressure relieving equipment (pressure mattress, cushions, boots, wedges) has been assessed and instigated where required; skin and continence assessments have been reviewed; and hydration and nutrition awareness has increased with monthly meetings with dietitian for advice and resident consultation occurring. Dietitian reviews all residents with a wound identified as pressure related.

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-service has been provided.

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

ARHSS D16.4;There is good specialist input into residents in the PG a unit. A Mental health consultant visits regularly as required, psychogeriatrician visits as required and the Nurse Practitioner for Older Person Mental Health (from Dunedin Public Hospital) visits regularly and is involved in the resident three monthly review. There was evidence that the Nurse Practitioner had been involved daily in one residents care, who was displaying severe behaviour issues. Strategies for the provisions of a low stimulus environment could be described.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

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

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

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

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

There are four activity coordinators, which includes two diversional therapists. There is also an outings officer and a specialised caregiver who assists in the psychogeriatric unit to calm residents.

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. This is an extremely well-designed and 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.

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

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

Resident meetings are held in the hospital and rest home every two months with feedback regarding activities provided at the meeting.

All ten residents (seven hospital level and three rest home level) and six family members (four with family in the hospital and two with family in the psychogeriatric unit) interviewed discussed enjoyment in the programme and the diversity offered to all residents.

Ryman Healthcare, as an organisation, have developed an exercise programme Triple A (Ageless, Active and Aware) that is implemented by activities staff at Yvette Williams Retirement Village. There is an activities section in the resident file that include and 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. This is a well-designed and comprehensive programme that meets the individual needs of the residents. The team is enthusiastic with evidence of the regular, on-going evaluation of the activities programmes through surveys of resident’s needs, regular resident/relative meetings and weekly activities staff meetings. The evaluation and implementation of changes to identified needs and suggestions promotes a culture of continuous quality improvement in the delivery of the activities programme and identification of individual needs of residents at Yvette Williams. The triple A (Active, Ageless, Awareness) exercise programme was designed by the Ryman group and includes chair exercises for hospital and psychogeriatric residents, and a more active exercise programme for rest home residents and serviced apartments. The programme is designed help maintain/improve residents mobility and balance and is part of the falls prevention programme. Activity staff are specially trained to implement the programme. There is a van available for outings and a specific employed activity person that is assigned to take residents on outings individually or as a group. They utilise mobility taxi’s for the special care residents. Family members are encouraged to participate. Interviews with ten residents (seven hospital level and three rest home level) report the activities programme is structured to meet their individual needs. Two of the six residents reported being introverted and didn’t enjoy group activities. Special one-on-one time, including outings such as shopping, ensure activities are suited to meet the individual needs of the residents.

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

ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered is included in the lifestyle care plan. Residents are quick to feedback likes and dislikes to the activity officer. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.

ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

**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:** FA

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

Short term care plans were cited for wounds, weight loss, UTIs, poor appetite, gastric infection, URTI and eye infections.

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

ARC: ARHSS D16.3c: All care plans were implemented by the RN within three weeks of admission

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

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

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

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

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the pharmacist and RN. Medication charts record prescribed medications by residents’ general practitioner, including PRN and short course medications.

Three medication administration rounds were observed. Medications and associated documentation is kept on the medication trolley in locked treatment rooms in the three areas and in a locked cupboard in the serviced apartments.

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

Controlled drugs are stored in a locked cabinet inside a locked treatment room on both floors. Controlled drugs are recorded and checked by two staff members in the controlled drug register. medication administration charts are signed by two staff following administration of controlled medication. Controlled drugs are checked weekly. Medication fridge’s are monitored weekly.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies are on all the drug charts.

All senior caregivers/RNs administering medication complete a medication package. Six monthly medication administration competency is completed of each staff member. Medication training and competencies last occurred in June 2013.

The service instigated a QIP following a medication error in June, with increased education with pharmacist, resulting in an improvement in medication knowledge with an internal audit result achieving 95% compliance.

There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available. There is currently no residents self-medicating at Yvette Williams.

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

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

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

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

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

The service has a large workable kitchen that contains a walk-in chiller and a pantry. The menu is designed and reviewed by a Registered Dietitian at an organisational level. There is a three monthly rolling menu.

All meals are cooked in the main kitchen and are transferred to the hospital and dementia units in insulated containers. Trays of food are then removed from the insulated transfer boxes and placed in warmed bain maries. Caregivers serve the food from bain maries in kitchenette areas in each unit. There are also snacks available over 24 hours for residents. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed by ECOLAB. There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets.

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

ARHSS D15.2f: there is evidence that there is additional nutritious snacks available over 24 hours

D19.2 All kitchen staff have completed Food Safety Certificates (NZQA).

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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

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

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

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

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

**STANDARD 1.4.2 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

Legislation and regulatory requirements appear to be met for local authorities and the MoH. Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which is posted in a visible location and expires on 14 October 2013.

**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:**

**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 is one enabler (bed rails) in use and 19 restraints (bed rails and chair briefs). Residents' files selected for audit include one resident using an enabler and two residents using restraint. Appropriate procedures are in place to manage the use of enablers and restraints, including exploring alternatives to restraint use.

ARHSS D16.6: There is a managing disturbed behaviour policy

**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 2.2.2 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 (one enabler and two restraints), three assessments were fully completed. Where a new type of restraint had been added (eg, chair briefs) to an existing restraint (eg, bedrails), a full assessment is documented for the additional restraint, evidenced in interview with the restraint coordinator. Note: no residents at present are applicable to this situation. This previously identified shortfall is now being met.

**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:**

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

**STANDARD 3.4 Education**

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

ARC D5.4e ARHSS D5.4e

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

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

Previous audit identified a shortfall with the Infection Control Officer not having completed external education, this shortfall has been addressed with the IC Officer having completed on- line training for IC nurses.

**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:**

**STANDARD 3.5 Surveillance**

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

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

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

The Surveillance policy states the routine/planned surveillance programme is organised and promoted via the RAP calendar. The IC/H&S committee meet monthly and also act as the IC committee. A monthly infection summary report is completed. The Surveillance includes a) systematic surveillance, b) response to surveillance activities, c) development of the surveillance programme, d) standardised definitions, e) surveillance methods, f) reports and g) assessment of effectiveness of surveillance. Surveillance methods and processes including implementation of an internal audit are appropriate for the size of this facility (rest home and hosp level). All infections are collected via the ' infection report form' and all collected and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report of generated. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers. The IC Officer 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 Yvette Williams Retirement Village includes discussion on infection control. Internal audits are completed hand washing audit, laundry hygiene audit, and kitchen hygiene audit. Infections are benchmarked across the organisation.

The service experienced a gastric outbreak in July 2013, with 32 residents affected in hospital unit. There was documented evidence of management of outbreak including meeting minutes with DPH ICN and staff briefings, increase of cleaning, special handling of linen, extra education moments with staff and usage of bureau staff. The service contained the outbreak to the hospital area.

**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:**