

Rowena Jackson Retirement Village Limited

CURRENT STATUS: 25-Sep-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

Rowena Jackson is a modern facility that is part of a wider village. The service provides care for up to 70 hospital residents in two wings, 61 rest home residents and 26 residents in a secure dementia wing (10 psychogeriatric and 16 dementia). Additionally, there are 15 certified serviced apartments. On the day of the audit, there were 68 hospital residents 67 rest home residents (including seven rest home residents in the serviced apartments) and 25 residents in the secure unit (four psychogeriatric and 21 dementia).

The one shortfall identified in the previous certification audit around care planning documentation is evidenced to have not yet been fully addressed. This audit identified there are improvements required around nursing assessments, documentation of long and short term care plans and medication management.

AUDIT SUMMARY AS AT 25-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
	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

Indicator	Description	Definition
	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 25-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 25-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.		Standards applicable to this service fully attained

Continuum of Service Delivery	Day of Audit 25-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 25-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.		Standards applicable to this service fully attained

Restraint Minimisation and Safe Practice	Day of Audit 25-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 25-Sep-13	Assessment
<p>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.</p>	  	Standards applicable to this service fully attained

Rowena Jackson Retirement Village

Rowena Jackson Retirement Village Limited

Surveillance audit - Audit Report
Audit Date: 25-Sep-13

Audit Report

To: HealthCERT, Ministry of Health

Provider Name Rowena Jackson Retirement Village Limited

Premise Name	Street Address	Suburb	City
Rowena Jackson Retirement Village	40 O'Byrne Street North	Waikiwi	Invercargill

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

Type of Audit	Surveillance audit and (if applicable)	
Date(s) of Audit	Start Date: 25-Sep-13	End Date: 26-Sep-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	XXXXXXX	RN, Auditor certificate	12.00	8.00	25-Sept-13 to 26-Sept-13
Auditor 1	XXXXXXX	RN, Auditor certificate	12.00	6.00	25-Sept-13 to 26-Sept-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXX			1.00	

Total Audit Hours on site	24.00	Total Audit Hours off site (system generated)	15.00	Total Audit Hours	39.00
Staff Records Reviewed	17 of 170	Client Records Reviewed (numeric)	10 of 153	Number of Client Records Reviewed using Tracer Methodology	4 of 10
Staff Interviewed	24 of 170	Management Interviewed (numeric)	5 of 5	Relatives Interviewed (numeric)	13

Consumers Interviewed	10 of 153	Number of Medication Records Reviewed	20 of 153	GP's Interviewed (aged residential care and residential disability) (numeric)	2
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Declaration

I, (full name of agent or employee of the company) XXXXXXXXXX (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 8 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

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
Rowena Jackson Retirement Village	172	153	20	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

Rowena Jackson is a modern facility that is part of a wider village. The service provides care for up to 70 hospital residents in two wings, 61 rest home residents and 26 residents in a secure dementia wing (10 psychogeriatric and 16 dementia). Additionally, there are 15 certified serviced apartments. On the day of the audit, there were 68 hospital residents 67 rest home residents (including seven rest home residents in the serviced apartments) and 25 residents in the secure unit (four psychogeriatric and 21 dementia).

The one shortfall identified in the previous certification audit around care planning documentation is evidenced to have not yet been fully addressed. This audit identified there are improvements required around nursing assessments, documentation of long and short term care plans and medication management.

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. Regular contact is maintained with families including if an incident or care/medical issue arises. The service has visiting arrangements that are suitable to residents and family. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution.

1.2 Organisational Management

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

A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. The orientation process includes a full induction for all employees and role specific induction training. For caregivers, training and competency modules are completed in addition to enrolment into the Aged Care Education programme. There is a strong commitment to staff development by way of education and in-service training. There are experienced registered nurses and enrolled nurses who provide leadership. Registered nurses are supported to maintain their professional competency. Employee training records are maintained.

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

1.3 Continuum of Service Delivery

Service delivery plans demonstrate service integration. Support plans are written on a computer programme. The plans identify who is responsible for the actions. Short term care plans are utilised for changes in health status, such as wound care, however, improvements are required whereby short term care plans are utilised for residents with gastro-intestinal infections. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly. There are areas noted for improvement around time frames for care plan development and documented nursing interventions.

There is one qualified diversional therapist and six activities co-ordinators that provide activities at Rowena Jackson. Activities are varied, age appropriate and include inclusion at local community and entertainment events.

The medication management system is appropriate and safely implemented with the exception of three residents charts. There are improvements required around GP signatures for regular medications and warfarin therapy and documentation of allergies. 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.

All staff have completed Food Safety Certificates (NZQA). 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. Two monthly resident meetings are held and meals are discussed. All residents interviewed stated that the food was good.

1.4 Safe and Appropriate Environment

The facility is purpose built. All building and plant have been built to comply to legislation. The service displays a current building warrant of fitness. The secure unit includes adequate space and two courtyards which are safe and secure with well-maintained paths and shaded seating areas.

2 Restraint Minimisation and Safe Practice

The restraint minimisation manual identifies that enablers are voluntary and the least restrictive option. Rowena Jackson Retirement Village currently has no residents requiring the use of an enabler or restraint. A restraint free environment is a goal of the quality plan identified by the facility. Restraint/enabler register reviewed evidences that the service has had an enabler/restraint free environment since February 2013. Education on restraint minimisation occurred 15-May-13 with 20 staff attending.

Care plans for residents in the dementia unit focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. Education on managing challenging behaviours occurred on 10-Sept-13 with 54 staff attending.

3. Infection Prevention and Control

Monthly collation tables of infection control data are forwarded to Ryman head office for analysis and benchmarking. The infection control policies are comprehensive and reflect best practice. Infection control (IC) training is provided at least annually to staff. There is an infection control register in which all infections are documented monthly. A six monthly comparative summary is completed.

Summary of Attainment

1.1 Consumer Rights

		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 1.1.6	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

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

1.2 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	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 1.2.7	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

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

1.3 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	PA Low	0	2	1	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	PA Low	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)	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 1.3.12	Medicine management	PA Moderate	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	5

Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 2 PA Neg: 0 PA Low: 3 PA Mod: 1 PA High: 0
 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0

Criteria (of 51): CI:0 FA:10 PA:4 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	Not Applicable	0	0	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	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

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:3 PA:0 UA:0 NA: 0

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	0	3
Standard 2.2.2	Assessment	Not Applicable	0	0	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

Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5
 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 21): CI:0 FA:1 PA:0 UA:0 NA: 0

3 Infection Prevention and Control

		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	Not Applicable	0	0	0	0	0	5
Standard 3.5	Surveillance	FA	0	2	0	0	0	8

Infection Prevention and Control Standards (of 5): N/A: 4 PA Crit: 0	CI:0 UA Neg: 0	FA: 1 UA Low: 0	PA Neg: 0 UA Mod: 0	PA Low: 0 UA High: 0	PA Mod: 0 UA Crit: 0	PA High: 0
Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0						

Total Standards (of 50) Neg: 0	N/A: 34 UA Low: 0	CI: 0 UA Mod: 0	FA: 12 UA High: 0	PA Neg: 0 UA Crit: 0	PA Low: 3	PA Mod: 1	PA High: 0	PA Crit: 0	UA
Total Criteria (of 219)	CI: 0	FA: 37	PA: 4	UA: 0	N/A: 0				

Corrective Action Requests (CAR) Report

Provider Name: Rowena Jackson Retirement Village Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date: 25-Sep-13 End Date: 26-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.3.3	1.3.3.3	PA Low	<p>Finding:</p> <p>The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy, with the following exceptions. a) Challenging behaviour assessments have not been conducted for two residents - one hospital and one dementia level care resident. The hospital resident has a behaviour management plan in place and monitoring has been conducted. The dementia resident does not have a long term care plan in place (overdue). b) One resident with pain issues from the rest home does not have a pain assessment conducted. Pain management is identified and recorded on the long term care plan for this resident. c) One dementia level care resident in the special care unit (no behaviour assessment completed) did not have a long term care plan in place and had been admitted to the unit 24 days prior and one rest home resident's care plan was developed two months after admission.</p> <p>Action:</p> <p>a) ensure all assessments are conducted as per identified resident issues and b) ensure all long term care plans are developed within expected time frames.</p>	3 months
1.3.6	1.3.6.1	PA Low	<p>Finding:</p> <p>Interventions in three of 10 files do not accurately record the full care requirements for the residents, i.e.: One hospital level resident has the use of an oxygen concentrator and prefers to sleep in a lazy boy chair, rather than a bed. This is not recorded in the long term care plan. One hospital resident has an indwelling catheter which according to the long term care plan was due for change on 27-Aug-2013 . No record of whether this had been changed during recent hospital stay. One rest home resident care plan states that the resident self-administers pain medication - advised by rest home coordinator that she does not.</p> <p>Action:</p> <p>Ensure all long term care plans record accurately the interventions required to meet the residents assessed needs.</p>	3 months
1.3.8	1.3.8.3	PA	Finding:	3 months

		Low	<p>Short term care plans not utilised for four resident files reviewed who were involved in a suspected gastro-enteritis infection/outbreak.</p> <p>Action: Ensure that short term care plans are utilised for all short term needs including infectious outbreaks.</p>	
1.3.12	1.3.12.1	PA Moderate	<p>Finding:</p> <p>a) Three medication charts (one regular packed medications, and two warfarin orders) are not signed by a GP; b) Six medication charts reviewed did not record allergies or nil known allergies.</p> <p>Action: a) Ensure all medication orders are appropriately signed; b) record all allergies or nil known allergies on all medication charts.</p>	1 month

Continuous Improvement (CI) Report

Provider Name: Rowena Jackson Retirement Village Limited

Type of Audit: Surveillance audit

Date(s) of Audit Report: Start Date: 25-Sep-13 End Date: 26-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXXX

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 families including if an incident or care/medical issue arises. A family contact stamp is used in resident files to indicate when family have been contacted.

Access to interpreter services is identified in the community and through the DHB interpreting services. There is one Chinese resident who speaks little English. The resident's family members are able to interpret for him and are involved in the care planning process and GP reviews.

Staff interviewed were able to describe that the resident is able to make his needs known through gestures and a few words of English and they are able to use cue cards if needed to promote better communication.

The resident was observed mobilising independently and interacting with staff when he required assistance.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

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

D16.4b Thirteen relatives (one rest home, eight hospital, three dementia and one psychogeriatric) report that they are kept informed when their family members health status changes. This is confirmed on review of a sample of thirteen incident forms reviewed which includes that family have been contacted after the incident.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

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

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on an electronic system (VCare).

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

Complaints are analysed using five separate categories; care, staff, finance, food and other.

A "Complaints six monthly Comparative Summary Report" from 01-Jan-13 to 30-Jun-13 was sighted. Rowena Jackson Retirement Village had received 15 complaints for this period. Six of the complaints were verbal complaints and nine were written complaints.

Four of the complaints received were related to care, two to staff, one to other and two regarding food.

All complaints have been resolved with the exception of one from a resident residing in the retirement village regarding the noise of the swimming pool heat pump.

Complaints and verbal complaints reviewed for 2013 are tracked for monitoring purposes to ensure that they are actioned according to timeframes determined by the Health and Disability Commissioner (HDC), and identify when a complaint is resolved.

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

Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

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

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

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

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

STANDARD 1.2.1 Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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

How is achievement of this standard met or not met?

Attainment: FA

Rowena Jackson is a modern facility that is part of a wider village. It provides care for up to 70 hospital residents in two wings, 61 rest home residents and 26 secure (10 psychogeriatric and 16 dementia) residents. Additionally, there are 15 certified serviced apartments. In the rest home, there are 10 swing beds, in the secure unit, there are 10 swing beds (allowing a maximum of 10 psychogeriatric residents). On the day of the audit, there were 68 hospital residents (39/40 in O'Byrne wing and 29/30 in Salisbury wing), 60/61 rest home residents and 25/26 secure unit residents (4 psychogeriatric and 21 dementia). Additionally, there were seven rest home residents in the serviced apartments. Rowena Jackson is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care.

In the previous audit report those residents requiring psychogeriatric level care were residing in one wing of the Special Care Unit. This audit identified on discussion with the village manager and clinical manger that psychogeriatric residents (4) were not confined to this one wing but were residing in rooms in other wings of the special care unit.

Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. For purposes of monitoring organisation performance, the village manager reports weekly to head office. The RAP committee meetings occur monthly.

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

The village manager is a registered nurse and has been the village manager at Rowena Jackson Retirement Village for nine years. She attends Ryman training three times a year. Ryman also offers eight managers an opportunity to identify areas to improve and individual training around specific areas is provided. The village manager is supported by an assistant manager who commences employment at the facility in October 2013, clinical manager (registered nurse) and a rest home coordinator (enrolled nurse), special care unit coordinator (registered nurse) and a village coordinator (enrolled nurse) who also supports the serviced apartments. The Management Resource Manual includes a number of documented responsibilities of the manager including a list of reporting requirements. There is a village manager's job description.

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

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

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

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

There are business objectives monitored throughout the organisation.

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

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

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

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

STANDARD 1.2.3 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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Rowena Jackson 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 Rowena Retirement Village at the onsite monthly RAP meetings and weekly management meetings.

Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with four registered nurses, one clinical manager (RN), one rest home coordinator (EN) and one SCU coordinator (RN) (dementia unit), quality coordinator, village coordinator and ten care assistants; and review of meeting minutes demonstrates staff involvement in quality and risk activities.

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

Resident meetings are held two-monthly in the rest home and in the hospital. Relative meetings are held six monthly. Minutes are maintained. There is evidence of sign off of corrective actions for meetings.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. The RAP programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's on-going progress on quality improvement.

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

Clinical policies and procedures are in place for the rest home, dementia unit and hospital. The two monthly journal club (attended by registered and enrolled nurses and directed by head office) reviews the latest clinical practice articles.

Journal topics are a reflection of the current environment. Topics that have been covered in the past six months include informed consent and urinary tract infections and falls prevention.

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

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

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

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

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

Meetings are minuted including actions to resolve areas identified for improvement and quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement. Meetings include the following: monthly RAP, full facility, activities, clinical in each area (rest home, hospital, apartments, dementia), enrolled nurse/registered nurse; two monthly health and safety including infection control, resident meetings; six monthly restraint and six monthly family meetings.

D19.3 Health and safety policies are implemented and monitored by the monthly health and safety committee meetings. A health and safety officer is appointed. Risk management, hazard control and emergency policies and procedures are in place. Ryman has tertiary level ACC WSMP to November 2013.

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

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

Rowena Jackson Retirement Village was one of two Ryman facilities selected to trial a new format for the documenting of quality improvement plans. where improvements are required the new format includes references to the corresponding Health and Disability Sector Standards and Criteria. Examples of Quality Improvement plans evidenced completed are;

- (a) Staff education on Basic Cares was provided in response to an increase in the number of residents with pressure area wounds. Care Assistants workshops on Basic Cares were evidenced completed in July and August 2013 with a total 45 staff attending.
- (b) Fire Drill completed in June 2013 identified that a clip board, maps, vest and checklist for delegations of tasks were needed that fire wardens could access. These were evidenced in place and have been signed off by the village manager as having been completed.
- (c) Fridge temperature monitoring- New digital thermometers have been purchased and are in place on all fridges to improve accuracy of recording.
- (d) It was identified that the Combioven in use in the kitchen had the potential to cause injury as it was too tall for staff to remove hot trays from safely. The legs of the combioven have been adjusted and shortened to address this issue.

Continuous Improvement Plans were evidenced in place for:

- (a) Vitamin D programme to reduce the risk of fractures,
- (b) restraint minimisation- to continue to maintain a restraint free environment. The service has been restraint an enabler free since February 2013.
- (c) Improving the induction process to achieve 100% currently 98%.
- (d) Staff wellness- Education on back care work shops were completed for staff in April 2013 with 71 staff attending. Staff have also completed safe handling and transfer of residents education in May, June, July and September 2013 with 93 staff attending.
- (e) Recognition of staff achievements- Excellence awards and employee of the month awards are distributed at monthly full facility meetings.
- (f) An RN/EN Journal Club meets to promote education, evidenced based practice and reflective learning.
- (g) To continue to encourage care assistants to complete ACE education- 58 staff have completed ACE education programme and 35 are currently enrolled in the ACE programme. The service recently entered the Health ED Trust competition for awards in education.

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH.

Outbreak notification to the DHB and Public health were sighted for two outbreaks of vomiting and diarrhoea which occurred in July and September 2013.

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required as sighted in 13 incident forms reviewed.

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

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

A review of incident/accident forms for Rowena Jackson Retirement Village identifies that 13 of 13 incident forms are fully completed and include follow-up actions taken.

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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

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

STANDARD 1.2.7 Human Resource Management

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

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

Rowena Jackson Retirement Village has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as caregiver, senior caregiver, registered nurse, health and safety representative, coordinators and activities. The orientation/induction training for caregivers, on completion, provides them with a level two national certificate in support of the older person.

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

All caregivers are encouraged and supported to complete the Aged Care Education (ACE) foundations within a one-year time frame - 58 staff have completed ACE education programme and 35 are currently enrolled in the ACE programme.

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

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

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

E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.
E4.5f; ARHSS D17.1: There are 24 caregivers who work in the special care unit (dementia care/psychogeriatric unit). Sixteen staff members have completed ACE dementia unit standards. Eight staff are in the process of competing dementia unit standards and five of those staff have commenced employment within the last six months.

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

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

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

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

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

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

Corrective Action Required:

Timeframe:

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

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

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

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

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

How is achievement of this standard met or not met?

Attainment: FA

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

Interviews with 10 caregivers state that overall the staffing levels are good although they are kept very busy. They report the registered nurses and enrolled nurses (including coordinators and clinical manager) provide good support. Relatives state that staff are visible when they visit and are readily available to meet their family's needs.

The clinical manager works Sunday-Thursday and covers all areas.

There is RN cover in the dementia/psychogeriatric unit across 24/7. There is a unit coordinator (RN) in each area who works Mon-Friday. There is an RN in the afternoon and night shift in the hospital.

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

There are contracted physiotherapists (2) who work nine hours per week over three mornings. There are two physiotherapy assistants employed who work 9am -1pm Monday to Friday.

Two rest home residents from the apartments state that they are well supported and their call bells are answered in a timely manner. There is a call bell audit that monitors response to the bell and this indicates that call bells are answered in a timely manner. Residents interviewed state that there are sufficient staff to provide support and to attend to cares.

In the Serviced apartments.

RN from rest home works Monday-Friday 1x registered nurse 0900-1430 and provides oversight to enrolled nurse in serviced apartments.

Sunday-Thursday 1x enrolled nurse 09.00-17.30

(Friday-Saturday village manager relieves the enrolled nurse 09.00-17.30)

Monday-Sunday 1x caregiver 07.00-15.30; 1x caregiver 07.00-13.00

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission. The nursing care assessments and long term care plans are to be completed within three weeks and align with the service delivery policy. However, it is noted that two long term care plans were not completed within the three week time frame and two residents did not have appropriate assessments completed for all identified issues. Improvements are required in these areas. 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. Activity assessments and activities care plans have been completed by the activity staff.

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 with some exceptions. InterRAI assessment tool is not currently in use.

D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours. A long term care plan is developed, and reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. Ten resident files were reviewed (four hospital, three rest home, two dementia and one PG files). Of the 10 files, all 10 have had the initial admission assessments and plans completed with the correct time frames and eight of 10 long term care plans have been completed within a three week timeframe. Two of 10 files did not have all required assessments completed.

D16.5e; Medical assessments were documented in all 10 long term files within 48 hours of admission. Three monthly medical reviews were documented in 10 of 10 files by general practitioner. It was noted in eight of 10 resident files reviewed identified that the GP has assessed the resident as stable and is to be seen three monthly, two files identified a monthly review. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

Assessment tools available for completion on admission include a) pressure area risk assessment, b) challenging behaviours, c) continence, d) mobility, e) falls risk, f) nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

ARHSS D16.6; One resident with behaviours that challenge were reviewed from the special care unit. Behaviours were well identified through the assessment process, monitoring forms and behaviour management plans were implemented.

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 are three house GPs involved with the service that visit weekly. An experienced service coordinator is responsible for residents in the serviced apartments. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Ten files reviewed evidence this is occurring. A weekly management meeting provides an opportunity to discuss any clinical issues.

The physiotherapist visits weekly and is contracted for nine hours. Two physiotherapy assistants provides physiotherapy support 20 hours a week as directed by the physiotherapist.

Two GP's interviewed stated that the service is prompt at informing of changes in their residents conditions and that their instructions are carried out.

Tracer Methodology: Hospital level resident

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 specific resident

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

Tracer methodology: Psychogeriatric 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: PA

Risk level for PA/UA: Low

D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours. A long term care plan is developed, and reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. Ten resident files were reviewed (four hospital, three rest home, two dementia and one PG files). Of the 10 files, all 10 have had the initial admission assessments and plans completed with the correct time frames and eight of 10 long term care plans have been completed within a three week timeframe. Two of 10 files did not have all required assessments completed.

D16.5e; Medical assessments were documented in all 10 long term files within 48 hours of admission. Three monthly medical reviews were documented in 10 of 10 files by general practitioner. It was noted in eight of 10 resident files reviewed identified that the GP has assessed the resident as stable and is to be seen three monthly, two files identified a monthly review. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

Finding Statement

The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy, with the following exceptions. a) Challenging behaviour assessments have not been conducted for two residents - one hospital and one dementia level care resident. The hospital resident has a behaviour management plan in place and monitoring has been conducted. The dementia resident does not have a long term care plan in place (overdue). b) One resident with pain issues from the rest home does not have a pain assessment conducted. Pain management is identified and recorded on the long term care plan for this resident. c) One dementia level care resident in the special care unit (no behaviour assessment completed) did not have a long term care plan in place and had been admitted to the unit 24 days prior and one rest home resident's care plan was developed two months after admission.

Corrective Action Required:

a) ensure all assessments are conducted as per identified resident issues and b) ensure all long term care plans are developed within expected time frames.

Timeframe:

3 months

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 Mal V CQ SQ STQ Ma L

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

Ten resident files were reviewed and included three rest home (two in the rest home and one in a serviced apartment), four hospital (three hospital unit and one residing in the rest home), two dementia level care and one psychogeriatric level care residing in the special care unit.

Of the 10 files reviewed, four of those residents were interviewed and all four 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 four registered nurses and two enrolled nurses verified involvement of families in the care planning process.

The long term care plans reviewed were supported by assessments (link # 1.3.3) and identify the level of intervention to meet the identified needs, and goals/objectives for seven of 10 files reviewed. Improvements are required for three resident care plans reviewed. There were short term care plans in eight of 10 files reviewed (link # 1.3.8). Five files showed a link between short term care planning and wound management plans.

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.

Wound assessment and wound management plans are in place for 27 residents. There are 41 wound care plans in place and include nine pressure areas. Six hospital residents have pressure injuries, three special care unit residents have pressure injuries - all grade one or two. Advised by the village manager that a quality improvement plan is being implemented to address this and includes education and training for staff and input from the Ryman wound specialist. Monthly collation of skin tears and pressure injuries is documented.

The Registered Nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. One rest home resident with a chronic leg ulcer has been seen by the DHB nurse wound specialist.

ARHSS D16.4; There is good specialist input into residents in the special care unit with assistance from older person's health nurse practitioner. 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: PA

Risk level for PA/UA: Low

Of the 10 files reviewed, four of those residents were interviewed and all four 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 four registered nurses and two enrolled nurses verified involvement of families in the care planning process.

The long term care plans reviewed were supported by assessments (link # 1.3.3) and identify the level of intervention to meet the identified needs, and goals/objectives for seven of 10 files reviewed.

Finding Statement

Interventions in three of 10 files do not accurately record the full care requirements for the residents, i.e.: One hospital level resident has the use of an oxygen concentrator and prefers to sleep in a lazy boy chair, rather than a bed. This is not recorded in the long term care plan. One hospital resident has an indwelling catheter which according to the long term care plan was due for change on 27-Aug-2013. No record of whether this had been changed during recent hospital stay. One rest home resident care plan states that the resident self-administers pain medication - advised by rest home coordinator that she does not.

Corrective Action Required:

Ensure all long term care plans record accurately the interventions required to meet the residents assessed needs.

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.

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

There is one diversional therapist and six activity coordinators. There is also an assigned lounge staff caregiver that supervises and provides activities to the residents in the special care 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. 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. There is a resident choir and a knitting group.

The activities programme is developed for a month and a copy of the programme is kept in each residents bedroom, in and on notice boards throughout the facility.

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

The triple A (Active, Ageless, Awareness) exercise programme was designed by the Ryman group and includes chair exercises for less active residents and more active exercise programme for mobile residents and serviced apartments. Residents were observed enjoying a triple A session and competition, music and entertainment, quiz, newspaper reading, one to one time, bowls and a bus outing. There are different levels of the programme depending on the mobility level of the residents. The programme in the special care unit is provided until 8pm at night for those residents who do not settle early.

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

All 10 residents (five rest home, five hospital) and 13 family members (one rest home, eight hospital, three dementia and one psychogeriatric level care) interviewed discussed enjoyment in the programme and the diversity offered to all residents.

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

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 Mal 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 special care unit. Any changes to the long term care plan are dated and signed. Seven care plans reviewed included handwritten updates to the plan as needs have changed (two new admissions and one plan not yet due).

Short term care plans were cited for wounds, weight loss, UTI's, poor appetite, skin conditions, and post fracture care. It was noted that four residents with recent gastro-enteritis like symptoms were not recorded on a short term care plan.

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

ARC: ARHSS D16.3c: The initial care plans are developed within 24 hours and evaluated within three weeks of admission prior to the long term care plan introduction. (link CAR 1.3.3.3)

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

Short term care plans were cited for wounds, weight loss, UTI's, poor appetite, skin conditions, and post fracture care. It was noted that four residents with recent gastro-enteritis like symptoms were not recorded on a short term care plan.

Finding Statement

Short term care plans not utilised for four resident files reviewed who were involved in a suspected gastro-enteritis infection/outbreak.

Corrective Action Required:

Ensure that short term care plans are utilised for all short term needs including infectious outbreaks.

Timeframe:

3 months

Attainment: PA

Risk level for PA/UA: Low

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

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

Medication administration was observed in the hospital, rest home and special care units by one registered nurse, and two enrolled nurses and one senior care giver. 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 or EN's in the hospital units (two) and senior caregivers/EN/RN in the rest home and special care unit 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 in two hospital units, in the rest home treatment room and in the special care unit treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly. Medication fridge's are monitored daily and recorded weekly.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos are on all 20 drug charts reviewed. Allergies or nil known allergies are recorded in 14 of 20 medication charts reviewed - improvement is required in this area.

All senior caregivers/RNs administering medication complete a medication package. An annual medication administration competency is completed of each staff member. Medication training and competencies last occurred in July 2013 with 26 staff attending.

There is a self-medication resident's policy in place. A self-medication assessment checklist is available. There are currently no residents who self-administer medications.

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements with the exception of three charts - regular medication orders not signed by the GP in one chart and two residents on warfarin had incomplete orders. 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. PRN medication orders all record indications for use.

D16.5.e.i.2; Twenty medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed in 19 of 20 charts reviewed.

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: Moderate

Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements with the exception of three charts. One resident's regular packed medication orders were charted in July 2013 but had not been signed by the GP; and two dementia residents medication orders were also not signed by a GP. The orders had been faxed to the service from the medical practice with orders documented by the practice nurse. No GP signature was recorded on the order. 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. PRN medication orders all record indications for use. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos are on all 20 drug charts reviewed. Allergies or nil known allergies are recorded in 14 of 20 medication charts reviewed.

Finding Statement

a) Three medication charts (one regular packed medications, and two medication orders) are not signed by a GP; b) Six medication charts reviewed did not record allergies or nil known allergies.

Corrective Action Required:

a) Ensure all medication orders are appropriately signed; b) record all allergies or nil known allergies on all medication charts.

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 Mal V CQ SQ STQ Ma L

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

All kitchen staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller, a freezer and a pantry. The menu is designed and reviewed by a Registered Dietitian at an organisational level. There is a three monthly rolling menu. Feedback from residents and families was positive and that there are alternatives to meals if required.

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

Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed by ECOLAB. There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets. Fridge temp audit 92.5% compliance generating a Ryman Quality Improvement Plan that is currently being applied by all staff. Food in fridges, freezer and pantry are labelled and dated. Decanted food is dated and time for rotation is recorded. Cleaning schedules are implemented.

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

E3.3f, ARHSS D15.2f: there is evidence that there is additional nutritious snacks available over 24 hours

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

Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**Audit Evidence****Attainment:** FA**Risk level for PA/UA:****Finding Statement****Corrective Action Required:****Timeframe:****Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.****Audit Evidence****Attainment:** FA**Risk level for PA/UA:****Finding Statement**

Corrective Action Required:

Timeframe:

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

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

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

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

These requirements are superseded, when a consumer is in seclusion as provided for by 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 Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Legislation and regulatory requirements are 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 expires on 18 November 2013. Fire and evacuation drill was last conducted in June 2013. A corrective action was generated following this drill to include maps, and lay out of facility for fire

wardens. There is a quiet lounge in the special care unit and all residents have single rooms. The special care secure unit includes two courtyards which are safe and secure with well-maintained paths and seating.

E3.4d, ARHSS D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; ARHSS D15.3e: The following equipment is available, pressure relieving mattresses, shower chairs, standing and sling hoists, heel protectors, lifting aids. Interviews with three caregivers from the special care unit confirmed there was adequate equipment.

E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; ARHSS D15.3b 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:

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

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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

How is achievement of this standard met or not met?

Attainment: FA

The restraint coordinator is the clinical manager (RN). The restraint minimisation manual identifies that enablers are voluntary and the least restrictive option. Rowena Jackson Retirement Village currently has no residents requiring the use of an enabler or restraint. A restraint free environment is a goal of the quality plan identified by the facility. Restraint/enabler register reviewed evidences that the service has had an enabler/restraint free environment since February 2013. Minutes of Restraint Approval Group meeting held 26-June-13 were sighted. Education on restraint minimisation occurred 15-May-13 with 20 staff attending.

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. Education on managing challenging behaviours occurred on 10-Sept-13 with 54 staff attending.

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:**

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

STANDARD 3.5 Surveillance

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

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

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

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

Ryman surveillance methods and processes including implementation of an internal audit. All infections are collected via the 'infection report form' and all collected and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report generated. There is an improvement required around trends being identified and acted upon by the IC officer. The IC Officer completes a monthly infection summary and a six monthly comparative summary is completed and forwarded to head office. IC Internal audits are completed and infection data is benchmarked across the organisation.

The service had an outbreak of Norovirus in the Serviced apartments in July 2013. The outbreak management report documents the infection control/prevention interventions implemented. Resident files reviewed have short term care plans completed which document the care and level of monitoring required and communication with family. Rosters were also reviewed to ensure there was no overlap of staff working in other areas of the facility. Rosters were sighted reflecting the changes to staffing to ensure the containment of the spread of infection.

During the one and half days of audit Salisbury wing (hospital) had two residents in isolation following an outbreak of vomiting and diarrhoea. Seven other residents had experienced similar symptoms and had been in isolation for 48 hours from last episode of vomiting/diarrhoea. Both residents were in isolation and infection prevention/control measures were evidenced implemented. However short term care plans were not evidenced completed. (link to #1.3.8.3) RN stated that faecal samples had been obtained and sent to the lab. Discussion with cleaning and laundry staff demonstrated that they were aware of the residents who were in isolation and described the management of cleaning and laundry process for these residents. Two caregivers interviewed from this wing were able to describe the infection control measures which were in place and the care each resident required. DHB and Public health have been notified by the clinical manager.

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:		