

# Grace Joel Retirement Village Limited

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Current Status: 16 October 2013

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

## General overview

Ryman Grace Joel is owned by Ryman Healthcare. The service has capacity for up to 117 residents including 20 certified serviced apartments. On the day of the audit there were 107 residents: 53 residents receiving rest home level care including 14 in serviced apartments and 54 residents receiving hospital level care. The manager has been at the service since May 2013 and has completed a comprehensive orientation. She is supported by a clinical manager who has been at the service also since May 2013 and has 15 years' experience in aged care. Families, residents and the general practitioner interviewed spoke very positively of the care provided. This audit has identified no areas requiring improvement.

## Audit Summary as at 16 October 2013

Standards have been assessed and summarised below:

### Key

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

## Consumer Rights as at 16 October 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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## Organisational Management as at 16 October 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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## Continuum of Service Delivery as at 16 October 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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## Safe and Appropriate Environment as at 16 October 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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## Restraint Minimisation and Safe Practice as at 16 October 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 16 October 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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## Audit Results as at 16 October 2013

### Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and services provided, is fully available to residents and

family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Staff training takes place on an annual basis, reinforcing delivery of care based on the rights of the residents and their family/whanau and their freedom of choice. Care plans reflect these core values and interviews with residents and family/whanau are positive about the service understanding and implementing their values and beliefs.

There is a Maori health plan and supporting policies that acknowledge the Treaty of Waitangi. The plan identifies culturally safe practices for Maori and recognition of Maori values and beliefs. The Maori health plan identifies the importance of whanau and this is seen as a highlight of the service.

On-going staff development through education and in-service training is strongly supported and this enhances the quality and risk management programme. Training and the delivery of service, supports evidenced-based practice. The complaints processes are implemented and complaints and concerns are actively managed.

Residents and family interviewed praised the care provided and Grace Joel in general and they state that the quality has vastly improved with the employment of the new management team.

### **Organisational Management**

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

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

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

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

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

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

## **Continuum of Service Delivery**

There is a needs assessment completed prior to entry to Grace Joel. Service delivery plans demonstrate service integration. Assessments and support plans are computerised and identify whom is responsible for the actions. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly.

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

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

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

## **Safe and Appropriate Environment**

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. There is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. The service has systems in place to manage consumers' physical environment. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. External areas are safe for residents and family members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

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

Regular fire drills are completed. Emergencies, and first aid are included in the training programme. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms and these are answered promptly.

## **Restraint Minimisation and Safe Practice**

There is a restraint minimisation manual that is applicable to the type and size of the service. The service completes assessments at admission and risks are included in the care plan interventions. Assessments are undertaken by suitably qualified and skilled staff (registered nurses) in discussion with the family.

The service has focused on reviewing all residents using restraints and enablers with an assessment and trial period without these. As a result, there are no restraints or enablers used in the service and no additional incidents related to residents with these removed.

Restraint/enabler competencies are completed by staff annually and the induction training includes specific training restraints/enablers. There is a restraint approval group at Grace Joel that oversees restraint minimisation practices with meetings occurring six monthly and as required.

### **Infection Prevention and Control**

Infection control is integrated as part of the bi-monthly health and safety meeting with discussion also at the RAP, staff and management meetings. Monthly collation tables from the facility are forwarded to Ryman head office for analysis and benchmarking. The infection control officer implements the surveillance, organises training and implements and reviews internal audits with oversight from the clinical manager.

The infection control policies are comprehensive and reflect best practice. Infection control training is provided to staff annually as is hand washing training. There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed. A six monthly comparative summary is completed.

The infection control officer has access to the District Health Board, general practitioners, wound nurse specialist and other specialists as required.

# HealthCERT Aged Residential Care Audit Report (version 3.9)

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## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

<b>Legal entity name:</b>	Grace Joel Retirement Village Limited		
<b>Certificate name:</b>	Grace Joel Retirement Village		
<b>Designated Auditing Agency:</b>	Health and Disability Audit NZ		
<b>Types of audit:</b>	Certification		
<b>Premises audited:</b>	<b>Grace Joel Retirement Village</b>		
<b>Services audited:</b>	Hospital – geriatric/medical and rest home		
<b>Dates of audit:</b>	<b>Start date:</b> 16 October 2013	<b>End date:</b> 17 October 2013	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			107

## Audit Team

<b>Lead Auditor</b>	XXXXXX	<b>Hours on site</b>	15.5	<b>Hours off site</b>	6
<b>Other Auditors</b>	XXXXXX	<b>Total hours on site</b>	15.5	<b>Total hours off site</b>	6
<b>Technical Experts</b>	XXXXX - observer	<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	32	Total audit hours off site	14	Total audit hours	46
Number of residents interviewed	14	Number of staff interviewed	31	Number of managers interviewed	3
Number of residents' records reviewed	11	Number of staff records reviewed	12	Total number of managers (headcount)	3
Number of medication records reviewed	22	Total number of staff (headcount)	123	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA Auditing Agency has finished editing the document.	Yes

Dated Wednesday, 13 November 2013



## Executive Summary of Audit

### General Overview

Ryman Grace Joel is owned by Ryman Healthcare. The service has capacity for up to 117 residents including 20 certified serviced apartments. On the day of the audit there were 107 residents: 53 residents receiving rest home level care including 14 in serviced apartments and 54 residents receiving hospital level care. The manager has been at the service since May 2013 and has completed a comprehensive orientation. She is supported by a clinical manager who has been at the service also since May 2013 and has 15 years' experience in aged care. Families, residents and the general practitioner interviewed spoke very positively of the care provided. This audit has identified no areas requiring improvement.

### Outcome 1.1: Consumer Rights

Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and services provided, is fully available to residents and family. There are policies to support rights such as culture, abuse / neglect, advocacy, privacy, dignity, informed consent, complaints and values and beliefs. Staff training takes place on an annual basis, reinforcing delivery of care based on the rights of the residents and their family/whanau and their freedom of choice. Care plans reflect these core values and interviews with residents and family/whanau are positive about the service understanding and implementing their values and beliefs.

There is a Maori health plan and supporting policies that acknowledge the Treaty of Waitangi. The plan identifies culturally safe practices for Maori and recognition of Maori values and beliefs. The Maori health plan identifies the importance of whanau and this is seen as a highlight of the service.

On-going staff development through education and in-service training is strongly supported and this enhances the quality and risk management programme. Training and the delivery of service, supports evidenced-based practice. The complaints processes are implemented and complaints and concerns are actively managed.

Residents and family interviewed praised the care provided and Grace Joel in general and they state that the quality has vastly improved with the employment of the new management team.

### Outcome 1.2: Organisational Management

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

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

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

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

the aged care education programme.

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

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

### **Outcome 1.3: Continuum of Service Delivery**

There is a needs assessment completed prior to entry to Grace Joel. Service delivery plans demonstrate service integration. Assessments and support plans are computerised and identify whom is responsible for the actions. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly.

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### **Outcome 1.4: Safe and Appropriate Environment**

There are waste management policies and procedures for the safe disposal of waste and hazardous substances. There is appropriate protective equipment and clothing for staff. The building holds a current warrant of fitness and holds a current approved evacuation scheme. The service has systems in place to manage consumers' physical environment. There is documented evidence available to indicate that hot water temperatures are being monitored and recorded on a regular basis. External areas are safe for residents and family members. Residents interviewed state their room and equipment is well maintained and that they are able to move freely around the facility.

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Regular fire drills are completed. Emergencies, and first aid are included in the training programme. There is a civil defence kit for the whole facility. Call bells are evident across the facility in resident's rooms, lounge areas, and toilets/bathrooms and these are answered promptly.

### **Outcome 2: Restraint Minimisation and Safe Practice**

There is a restraint minimisation manual that is applicable to the type and size of the service. The service completes assessments at admission and risks are included in the care plan interventions. Assessments are undertaken by suitably qualified and skilled staff (registered nurses) in discussion with the family.

The service has focused on reviewing all residents using restraints and enablers with an assessment and trial period without these. As a result, there are no restraints or enablers used in the service and no additional incidents related to residents with these removed.

Restraint/enabler competencies are completed by staff annually and the induction training includes specific training restraints/enablers. There is a restraint

approval group at Grace Joel that oversees restraint minimisation practices with meetings occurring six monthly and as required.

### Outcome 3: Infection Prevention and Control

Infection control is integrated as part of the bi-monthly health and safety meeting with discussion also at the RAP, staff and management meetings. Monthly collation tables from the facility are forwarded to Ryman head office for analysis and benchmarking. The infection control officer implements the surveillance, organises training and implements and reviews internal audits with oversight from the clinical manager.

The infection control policies are comprehensive and reflect best practice.

Infection control training is provided to staff annually as is hand washing training.

There is an infection control register in which all infections are documented monthly. A monthly infection control report is completed. A six monthly comparative summary is completed.

The infection control officer has access to the District Health Board, general practitioners, wound nurse specialist and other specialists as required.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	4	0	1
<b>Criteria</b>	0	0	0	0	0	8	0	0

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

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## Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

### Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

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

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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Policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the Code.
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Staff receive training for rights at induction and on-going – last provided in April 2013. Discussions with staff including 13 caregivers show an understanding of the key principles for the Code of Consumer Rights in providing services.
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Fourteen residents interviewed (three hospital, nine rest home, two serviced apartment) and seven of seven family interviewed including five hospital, one rest home and one serviced apartments state that their rights are upheld and staff treat them with respect and give dignity to them.
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### Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

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

<b>Attainment and Risk:</b> FA
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<b>Evidence:</b>
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<b>Finding:</b>
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<b>Corrective Action:</b>
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<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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## Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Interviews with 14 residents interviewed (three hospital, nine rest home, two serviced apartment) all confirm that information has been provided around advocacy.

D6, 2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and Health and Disability Commission.

### Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

#### Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The facility provides physical, visual, auditory and personal privacy for residents.</p> <p>During the visit, staff demonstrated gaining permission prior to entering resident private areas. Thirteen caregivers interviewed (seven hospital, six rest home, two serviced apartments with staff across AM, PM and night shift) describe ensuring privacy by knocking before entering.</p> <p>The service has a policy in place that includes that personal belongings are not used as communal property.</p> <p>Values and beliefs information and resident preferences are gathered on admission with family involvement and are integrated with the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with 13 caregivers identified how they get to know resident values, beliefs and cultural differences.</p> <p>Interviews with 14 residents confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities.</p> <p>Interviews with 13 caregivers (across night, am and pm shifts) describe providing choice including what to wear, food choices, how often they want to shower, activities and whether they want to be involved in activities.</p> <p>The village and assistant managers describe 'aging in place' and assisting residents to stay in their serviced apartment with increased support when residents assessed as requiring rest home level.</p> <p>There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years. Abuse and neglect training was last delivered in July 2013. There are two competency questions included in the induction programme around abuse and neglect which staff have completed (sighted in 12 of 12 staff files reviewed). Staff competency questionnaires are also completed as part of the RAP programme, these include questions around abuse and neglect and are completed annually by staff.</p> <p>Discussions with 14 residents and seven family members were overall positive about the care provided and they state that the care and support has significantly improved since the appointment in May 2013 of the village and clinical managers and assistant manager.</p>

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

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

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

**Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>



**Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)**

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff receive cultural training in 2011 with this scheduled for November 2013. Cultural needs and support is identified in care plans.

There is an established Maori Health plan and individual care plans include the cultural needs of residents.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). D20.1i The service has developed a link with Orakau marae and through the Auckland District Health Board. The village manager has sent an email (dated 2 October 2013) to ADHB to introduce herself and to establish a point of contact if support is required for Maori residents.

The policies for Māori identify the importance of whānau and 13 caregivers and registered nurses interviewed including the clinical manager discussed the importance of family involvement.

Discussion with seven family members confirms that they are regularly involved.

Interviews with the clinical manager, hospital coordinator, three registered nurses, one enrolled nurse, serviced apartment coordinator (enrolled nurse) and 14 caregivers confirms that they understand support for residents identifying cultural needs.

#### **Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)**

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

#### **Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

#### Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

#### Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans (sighted in 11 resident care plans: five hospital, six rest home).</p> <p>D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment and including any needs in the plan and review.</p> <p>Eleven of 11 files reviewed (five hospital, six rest home including two serviced apartments) include the residents social, spiritual, cultural and recreational needs.</p> <p>D4.1c During the admission process, an registered nurse (or an enrolled nurse in the service apartments with sign off and overview from a registered nurse) along with the resident and family whenever possible complete the documentation and this includes recognition of the resident culture, values and beliefs.</p>

### Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

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

ARHSS D16.5e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. One enrolled nurse, the serviced apartment coordinator (enrolled nurse) and three registered nurses (one hospital and two rest home) interviewed are able to describe appropriate boundaries between staff and residents and their families. Fourteen residents interviewed (three hospital, nine rest home, two serviced apartment) and seven of seven family interviewed including five hospital, one rest home and one serviced apartment did not identify any incidents related to discrimination and there are no incidents citing discrimination noted on review of the incident forms and incident data for 2013. Care plans reviewed (11 of 11) include the residents social, spiritual, cultural and recreational needs. Staff have had training on the code of conduct and staff competency in August 2013.

### Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a thorough and individualised Ryman Accreditation Programme (RAP). This programme includes using some indicators from the standard on safe indicators in aged care and for rest homes/hospitals for falls rate and urinary tract infections targets. Care planning is holistic and integrated. There is a strong commitment to staff development by way of education and in-service training.</p> <p>A2.2 Services are provided at Grace Joel that adhere to the health and disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.</p> <p>D1.3 All approved service standards are adhered to with this certification audit not identifying any required improvements.</p> <p>The service has objectives that have been reviewed and documentation of the review reflects best and evidence based practice. Examples of changes that have continued or are being implemented since the new management team has been appointed in May 2013 include the following: participation in the ACC vitamin D initiative to reduce falls in the elderly (71% of residents approximately on the supplement), employment of a wound nurse (experienced registered nurse) to support staff with wound management, removal of restraint with a focus now on continuing to keep the service restraint free with other strategies implemented to manage falls and behavioural issues, a focus on preparing separate meals for residents choosing this (note that dietary needs are also catered for), better recording of incidents with a focus on exploring other ways of ensuring that residents are not bruised (supported by the removal of bed rails), appointment of a back care champion, introduction of food training workbooks (with completion by kitchen staff).</p> <p>Fourteen residents interviewed (three hospital, nine rest home, two serviced apartment) and seven of seven family interviewed including five hospital, one rest home and one serviced apartments interviewed praised the service for the Grace Joel use of resident centred and the participation based model of care for residents. These models ensure that staff liaise with the resident for the best outcome.</p> <p>The management team including the village manager, assistant manager and clinical manager are looking at ways to improve resident's lives through the</p>

quality and risk management programme and through a team approach to management and leadership. Discussions individually with the clinical manager, village manager, assistant manager indicate that there is a strong team approach with each having defined areas of responsibility. There is evidence of robust discussion of issues through the weekly management meetings and through the RAP meetings.

**Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry</p> <p>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b Seven of seven relatives state that they are always informed when their family members health status changes.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</p> <p>Policies and training support staff in providing care and support so that residents can make choices and be involved in the service.</p> <p>Interviews with 13 caregivers interviewed (seven hospital, six rest home, two serviced apartments with staff across AM, PM and night shifts) identify that consents are sought in the delivery of personal cares and this is confirmed by 14 of 14 residents.</p> <p>Incident forms reviewed indicate that family are informed following an incident.</p>

There are no residents currently who identify as requiring an interpreter however the staff are able to describe how an interpreter would be accessed. Access to interpreter services is identified in the community. This includes language support, the DHB, Hearing Association and the Blind Foundation. As there is a multi-cultured staff and residents, caregivers described being able to interpret for some residents when needed.

There are two XXXX residents and one file reviewed confirms that dietary preferences are met.

There is a XXXXX family and the family have left cue cards for staff to use when talking with her.

A XXXXX resident has family who stay with her with her when she is awake. Family members interviewed felt that they were involved in decision making around the care of the resident.

**Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

**Attainment and Risk:** FA

**Evidence:**

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with 13 caregivers (seven from the hospital and six from the rest home including two from serviced apartments), identify that consents are sought in the delivery of personal cares and this is confirmed by 14 residents (nine from the rest home, three from the hospital and two from serviced apartments). Written consent includes the signed admission agreements and medical care guidance plan and care plans acknowledgement document. All 11 resident files (five from the hospital and six from the rest home including two from serviced apartments) reviewed has signed consent forms. Advanced directives / resuscitation policy is implemented in all 11 resident files reviewed. Resuscitation forms are reviewed annually. Three registered nurses (one from the hospital and two from the rest home) were able to discuss that residents unable to make a decision are to have resuscitation attempted.

D13.1 t There were 11 admission agreements sighted and all had been signed.

D3.1.d Discussion with seven family (five from the hospital, one from the rest home and one from a serviced apartment) identified that the service actively involves them in decisions that affect their relatives lives.

### Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)



**Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)**

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Advocacy information is part of the service entry package and is on display on noticeboards around the facility.  The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is</p>

documented on the front page of the resident file as confirmed by the residents and family interviewed.  
 D4.1d; Discussion with seven of seven family interviewed including five hospital, one rest home and one serviced apartment identifies that the service provides opportunities for the family/EPOA to be involved in decisions.  
 ARC D4.1e: The resident file includes information on residents family/whānau and chosen social networks as sighted in 11 of 11 files reviewed (five hospital, six rest home including two serviced apartments).  
 The complaints folder indicates that complainants are informed that they can access advocacy services to support them if needed.

**Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)**

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)**

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

**Attainment and Risk:** FA

**Evidence:**

The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations.  
 D3.1: Discussion with seven of seven family indicates that they are encouraged to be involved with the service and care including being informed of care planning reviews with an invitation to participate.  
 D3.1.e: Discussion with staff and relatives indicates that they are supported and encouraged to remain involved in the community and external groups such as church, bowls, shopping, events in the community, library.  
 Visiting in the service can occur at any reasonable time. Interviews with 14 residents, seven relatives confirm visitors are welcome, are included in discussions and asked if they would like a cup of tea and visitors were sighted coming and going on the days of the audit and engaging in activities with the resident.  
 There are two forms in each resident file: a) a contact form re who to contact in the event of an incident with differing levels of incidents review; b) a care plan acknowledgement document which is signed by the resident or family. These are completed in 11 of 11 files reviewed (five hospital, six rest home including two serviced

apartments).

**Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)**

Consumers have access to visitors of their choice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

**Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

### Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

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

**Attainment and Risk:** FA

**Evidence:**

D13.3h. The service has in place complaint management policies and procedures that are aligned with Code 10 of the Code of Rights. A complaints register/folder is in place that documents complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau as stated by 14 residents interviewed (three hospital, nine rest home, two serviced apartment) and seven of seven family interviewed including five hospital, one rest home and one serviced apartment. The entry pack includes a summary of the complaints procedure. The complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. A separate register is maintained for the rest home and the hospital. Complaints are documented on VCare. Complaints and verbal complaints reviewed for 2013 (two written and two verbal) tracked indicate that they had been actioned according to timeframes and identified resolution. The monthly staff meeting identified discussion of complaints and opportunities for improvement in service delivery. All of the complaints have documentation and management of a full investigation, follow ups and resolution including communication with complainants. The village manager and the assistant manager manage the complaints and report to the others in the management team including the clinical manager. Resolution of the complaints has been completed with better documentation of the process since the management team has been appointed in May 2013. Residents and family confirm they are aware of the complaints process and they would make a complaint to the managers if necessary. There are no complaints with the Health and Disability Commissioner, DHB or MoH. One complaint with the Health and Disability Commissioner in 2013 has been fully investigated and closed out by the Commission with the complaint being unsubstantiated.

#### Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

### Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## 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 (HDS(C)S.2008:1.2.1)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Grace Joel is a modern facility that is part of a wider village. Grace Joel is one of Ryman healthcare retirement villages. The care centre is modern and spacious. The facility is built across five floors and is designed around a large atrium and courtyards with the rest home on level one and the hospital beds on level two. It provides rest home and hospital level care for up to 107 residents. Additionally, there are 80 serviced apartments with 20 certified to be able to provide rest home level care.</p> <p>Occupancy is 53 rest home residents (including 14 in the serviced departments) and 54 hospital residents.</p> <p>There is a medical component to the certificate and there are currently no residents under this. There is a contracted physiotherapist who comes into the service daily and a physiotherapy aid who provides 40 hours a week support. The manager described a link to a community dietitian if required. There are two doctors who visit each once a week and are able to come in if required.</p> <p>There is a board and the Grace Joel monthly reports are escalated to the board through the managers to head office to the CEO.</p> <p>There is a documented service philosophy and objectives set at head office that guide quality improvement and risk management in the service.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually.</p> <p>There are robust quality and risk management systems implemented across Grace Joel that is monitored closely by head office. To monitor organisation performance, the manager reports monthly to head office and RAP committee meetings occur monthly (reports and minutes sighted for 2013).</p>

Ryman Healthcare have operations team objectives 2013 that include a number of interventions/actions for a) quality system focus forward, b) national dementia project, human resources - recruitment/induction processes, H&S, InterRAI project, and clinical education. The organisation wide objectives are translated at each Ryman service by way of the Ryman Accreditation Programme (RAP) that includes a schedule across the year. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme (RAP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation and there are clear guidelines and templates for reporting. Grace Joel has objectives that cascade from the Ryman head office around orientation, communication for staff, staff morale, wound care, infection analysis, health and safety. These are reviewed three monthly with reviews showing progress against objectives. The service has in place a village manager who has extensive experience in management and sales including Australian State management. ARC,D17.3di (rest home), D17.4b (hospital): The manager has maintained at least eight hours annually of professional development activities related to managing a hospital including attendance at the Ryman healthcare conferences and an induction through the Ryman head office and similar facilities. The village manager is supported by the regional manager and the systems manager (supported the village manager on the days of the audit). She is supported by an experienced clinical manager (NZRN, BHSc) with 90 credits towards a post graduate diploma in counselling, certificate in teaching, completion of a post graduate paper on assessment and intervention for the adult and older adult (previous experience as a senior lecturer in nursing and a clinical manager at another aged care facility for rest home and hospital residents). An assistant manager has over five years in administration and quality in other Ryman facilities and provides facilitation for the quality and risk management programme.

**Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> D19.1a; A review of the documentation, policies and procedures and from discussion with staff identifies that the service operational management strategies, quality and risk management programme which includes culturally appropriate care, is to minimize risk of unwanted events and enhance quality of service delivery for residents and other stakeholders. In the temporary absence of the village manager, the assistant manager fulfills the operational duties with support from the clinical manager. The assistant manager has been with Ryman facilities in administrative roles for over five years and is taking a leadership role at Grace Joel in quality including health and safety. She is able to describe the role of providing leadership in the absence of the village manager with the support of the regional and systems managers.

### Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)**

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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>Grace Joel 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 Grace Joel through the onsite monthly RAP meetings and weekly management meetings.</p> <p>Quality and risk performance is reported across the facility meetings and also to the organisation's management team.</p> <p>Discussions with three registered nurses, one enrolled nurse, the serviced apartment coordinator (enrolled nurse), the chef, hospital coordinator, five activities coordinators and 13 caregivers and review of meeting minutes demonstrate their involvement in quality and risk activities. The monthly staff meeting includes discussing and planning of the 2013 quality goals for the year and the objective are reviewed quarterly with evidence of progress against goals.</p> <p>Resident meetings are held on a two monthly basis in the rest home and in the hospital. Relative meetings are held six monthly. Minutes are maintained and one family member states that she finds the meetings valuable as a way to communicate ideas. Annual resident and relative surveys are completed. The last resident and relative survey was completed in October 2012. Action plans are completed with evidence that suggestions and concerns are addressed.</p> <p>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. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar.</p> <p>The monthly and annual reviews of the quality and risk management programme reflect the service's on-going progress around quality improvement.</p> <p>D5.4: There are adequate clinical policies and procedures to rest home and hospital level care including pain management, continence, personal grooming, skin integrity, wound management. The monthly journal club (attended by registered/enrolled nurses), directed by head office, reviews the latest clinical practice articles and provides registered nurses and enrolled nurses with clinical knowledge and evidence to support decision making.</p> <p>D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings that also include review of infection</p>



control and of incidents. A health and safety officer is appointed and the assistant manager takes overall responsibility with support for the newly appointed officer. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies.

Ryman has tertiary level ACC WSMP to November 2013. The organisation's benchmarking programme identifies key areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk. D19.2g Falls prevention strategies such as hi lo beds, completion of the post falls protocol, landing mats, physiotherapy assessments, regular checks, sensor mats are in place.

The following meetings ensure that there is robust discussion of quality data at all levels: weekly clinical management, two monthly health and safety, weekly link meetings (an extra meeting for the service to improve communication with the heads of departments with the managers), monthly activities meetings, monthly registered nurse/enrolled nurse, two monthly resident, six monthly hospital, monthly RAP meetings, bi-monthly housekeeping with the village manager, monthly full staff.

There is an implemented internal audit schedule that is completed in a timely manner. Corrective action plans are routinely raised with evidence of resolution of issues.

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

Annual resident and relative surveys are completed with the 2013 survey ready for circulation.

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

A spot audit is completed against the standards by the assistant manager - last in March 2013 and September 2013. There is a corrective action plan for each with evidence of resolution of issues.

Discussions with three registered nurses (one from the hospital, two in the rest home) and 13 caregivers and review of meeting minutes demonstrate their involvement in quality and risk activities.

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

### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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

**Attainment and Risk:** FA

**Evidence:**

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

The village manager is able to identify that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH, changes in managers.

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.

A review of incidents in files reviewed indicates that any falls have a post falls analysis completed and neurological observations are completed when applicable (sighted for two residents who had falls that involved a head injury).

The data is tabled at meetings held in the facility including minutes of the monthly RAP committee meetings, registered nurse/enrolled nurse meetings, two monthly health and safety meetings and monthly full facility meetings.

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

A review of 24 incident/accident forms for Grace Joel (12 hospital and 12 rest home) identifies that all are fully completed and include follow-up.

Family interviewed confirm that they are informed of incidents as these occur.

The village manager, assistant manager and clinical manager have focused on improving quality of reporting using incident forms and in analysis of incidents with improvements made in documentation since their arrival in May 2013. A review of 11 of 11 files reviewed (five hospital, six rest home including two serviced apartments) noted that all incidents identified in progress notes are documented on an incident form, appropriate recordings completed for the resident e.g. neurological observations when a fall involved a head injury and completion of the post falls analysis when relevant. The careplans also linked to the progress notes and to the incident forms which all showed review by the clinical manager and sign off in a timely manner.

The village and assistant managers are also involved in the incident process with the weekly management meetings and informal meetings during the week providing an opportunity to review any incidents as they occur.

### Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Twelve of 12 staff files reviewed include a signed contract, job description relevant to the role the staff member is in, police check, induction, application form and reference checks. A register of registered nurse practising certificates is maintained within the facility. The current general practitioners' registration is printed from the professional body's website. Practicing certificates for other health practitioners are retained to provide evidence of registration as appropriate (for example dietician and podiatrist) - sighted all as being current. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Twelve of 12 staff files were reviewed across a range of levels including registered nurse, chef, caregivers, housekeeping activities, assistant manager and clinical services manager. All included the relevant referee checks and training and development records.

Grace Joel 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 officer, clinical manager and gardener. The orientation/induction training for caregivers, on completion, provides them with a level two national certificate in support of the older person. This was a quality initiative by Ryman in 2010 and is monitored by the organisation. Currently any new caregiver is working through completing foundations level two as sighted in two staff files for new caregivers. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent.

There is an implemented education plan 2012 and 2013. The annual training programme well exceeds eight hours annually noting that there is a large number of staff attending each session.

Yearly formal performance allow for reflective practice and setting goals including up skilling or other training or qualification goals and all files reviewed include a current performance appraisal.

Registered nurses are supported to maintain their professional competency. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. Interviews with three registered nurses and one enrolled nurse identified that participation in the RN Journal Club is used to advise current practice and provide clinical updates and guidance.

D17.7d: There are implemented competencies for registered nurses and caregivers related to specialised procedure or treatment including medication competencies and insulin competencies. Seven of the 12 files reviewed had registered nurse/enrolled nurse or caregivers who are required to have a medication competency completed and seven of seven have these completed annually.

The Ministry of Health requested that the auditors check that the service has completed training around the Crimes Act in response to an unsubstantiated complaint with the Health and Disability Commissioner in 2013. All staff have completed this training in April 2013 (training files and attendance records reviewed).

There are attendance registers for each training session and an individual staff member record of training and evaluations of all training provided.

**Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

**Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>



**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)**

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

**Attainment and Risk:** FA

**Evidence:**

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

The following staff are rostered:

Hospital (54 residents): AM – hospital coordinator, two registered nurses, 7 caregivers (four short shifts of six hours). PM - 2 registered nurses, 5 caregivers (including two from 1630-2300 and one from 1600-2100). Night - 1 registered nurse and 2 caregivers.

Rest home (53 residents including 14 in serviced apartments): AM – two registered nurses, six caregivers including two short shifts. PM - four caregivers including two short shifts and one dining room assistant, one registered nurse. Night – three caregivers and one registered nurse (one of these caregivers at night also covers the serviced apartments overnight, however, they are based in the resthome). The Serviced Apartment has a Co-ordinator on the AM shift 7 days per week who is an enrolled nurse and there are caregivers on the AM shift and on the PM shift who oversee the cares of all resthome residents in the serviced apartments.

There are 123 staff in the facility including the village manager, clinical manager, assistant manager, hospital coordinator, serviced apartment coordinator, wound nurse specialist, 21 registered nurses/enrolled nurses, 64 caregivers, seven activity staff, chef and seven other kitchen staff. There are also cleaners and laundry staff seven days a week and maintenance staff and gardeners.

Staff on the floor on the days of the audit are visible and are attending to call bells in a timely manner as confirmed by all residents interviewed (14).

Interviews with 13 caregivers (seven from the hospital, six from the rest home including two from the serviced apartments) state that overall the staffing levels are satisfactory and that the management team provides good support. The caregivers interviewed state that the registered nurses and enrolled nurses are responsive on the whole and they can access the clinical manager if needed. The registered nurses and enrolled nurses state that they can access the hospital coordinator (newly appointed) and the clinical manager for support.

14 residents interviewed and seven family members interviewed report there is adequate staff numbers.

### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time.</p> <p>Policies outline security of records. Files are kept in a secure cupboards behind the nurses station in all areas.</p> <p>Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public.</p> <p>D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse/enrolled nurse including designation.</p> <p>Each resident has an individual file that includes all relevant information. Medication files are kept in a separate folder and this is appropriate to the service.</p> <p>The medication files are located in locked medication rooms. When medication is taken out to administer, the folders are kept on the trolleys in sight of the registered nurse or caregiver administering the medication – observed to occur in the rest home and hospital (trolleys are not left unattended).</p>

**Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)**

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)**

All records pertaining to individual consumer service delivery are integrated.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Outcome 1.3: Continuum of Service Delivery

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

### Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b    ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive admission policies including: a) entry of resident to services policy. The information booklet answers a number of questions around admission and entry processes. Information gathered at admission is retained in resident's records. Fourteen residents (nine from the rest home, three from the hospital and two from serviced apartments) interviewed confirmed they received information prior to admission and discussed the admission process with the facility manager.

### Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

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

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

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

### Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

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

**Attainment and Risk:** FA

**Evidence:**

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 completed within three weeks and align with the service delivery policy. The nursing care assessment and service delivery policy and nursing care assessment and planning interventions policy describes the responsibility

around documentation.

Wound care folders evidenced in all areas and assessments are signed by a registered nurse. Activity assessments and activities care plans have been completed by the activity therapists.

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

D16.2, 3, 4; An assessment and initial care plan is completed within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months in nine of 11 resident files (five from the hospital and six from the rest home including two from serviced apartments). Two residents have not yet been at the service for six months. All 10 long term files (one of the 11 file's was a respite resident), the initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe.

D16.5e; Medical assessments were documented in all 11 long term files within 48 hours of admission. Three monthly medical reviews were documented in 11 of 11 files by general practitioner (link 1.3.6.1). It was noted in nine of 11 resident files reviewed identified that the GP has assessed the resident as stable and is to be seen three monthly, one files identified a monthly review and one file has recently changed to weekly review. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

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

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. There is a duty handover supplement document which is completed for each shift that lists staff allocations, notes any residents requiring any special observations or needs and also advises of who is on call and who is the designated fire warden for that shift. There are twohouse GP's involved with the service and each visits at least weekly.

There is a GP clinic on site. An experienced service coordinator who is a registered nurse is responsible for residents in the services apartments.

Progress notes are maintained. Progress notes are written at least daily or more frequently as required. All files have a registered nurse weekly summary in the progress notes which summarises the residents progress for the past week. Eleven files reviewed evidence this is occurring. A weekly management meeting provides an opportunity to discuss any clinical issues.

The physio visits daily and a physio assistant provides physio support 40 hours a week as directed by the physio.

One GP interviewed stated that the service is excellent. She reported excellent communication and believes the care provided is of the hisghest standard.

Tracer Methodology hospital:

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

Tracer methodology rest home:

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

**Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)**

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whanau support, activities preferences, food&amp; nutrition information and mental function.</p> <p>Risk assessment tools and monitoring forms are available and implemented to assess level of risk and required support for residents including (but not limited to); Waterlow pressure area risk assessment, Coombes falls assessment, pain assessment, nutritional assessment and continence assessment. Behaviour assessments and monitoring forms are completed for three files reviewed where the resident presents behaviours that challenge. The nursing care assessment policy provides guidance in the use of assessment tools. Assessment tools are reviewed and completed six monthly or earlier if there is a change in health status.</p> <p>An initial support plan is completed within 24 hours. The nursing assessment links to the care plan and this was evident in the ten long term care plans reviewed (one resident is on respite care). The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation.</p>

**Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>



**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)**

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

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

**Attainment and Risk:** FA

**Evidence:**

Eleven files were reviewed:

Hospital: one resident with weight loss, one resident with on-going pain, two residents with behaviours that challenge and one resident receiving palliative care.

Rest home: one resident on respite care, one resident with difficult to manage pain, one resident with behaviours that challenge and one resident with several recent falls.

Serviced apartments: one resident with weight loss and one resident who is a diabetic.

There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality.

Each area of the care plan includes: problems/needs, objectives and interventions. Overall the 11 files reviewed reflected current needs. One respite resident who has been at the service for four days did not have the respite care plan fully completed at the beginning of day one of the audit. This was fully completed during the first day of the audit. The sample was increased to include the other two respite resident's files around care plans and both had fully completed care plans.

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

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

D16.3f; Eleven resident files reviewed identified that family were involved.

### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)**

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)**

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

**Attainment and Risk:** FA

**Evidence:**

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

Of the 11 files reviewed, five of those residents were interviewed and all five reported their needs were being appropriately met. The care plan includes; cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, medication, ADLs, skin, wound and pressure care, pain, dietary/diabetes management, and social, spiritual, cultural and sexuality. Care plans were current and family were invited to attend review meetings (correspondence noted in files reviewed). Interview with three registered nurses verified involvement of families in the care planning process.

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

There were short term care plans in 10 of the 11 files reviewed.

Six 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/skin tear plans are in place for 14 wounds in the hospital and 16 wounds in the rest home. There are no current pressure areas. Each wound folder has a wound and skin tear register. Evaluations, wound assessments and pain level is carried out at each dressing change. Wound mapping charts and photographs are evident as required. The service has employed a wound specialist and there is evidence of wound specialist input for each wound/skin tear registered. The chronic wound for one hospital resident is linked to the long term care plan. The registered nurses interviewed (three) also have access to external to wound specialist as required. The service employs a wound nurse who works at Edmund Hillary for 24 hours per week. She has 10 years district nursing experience and for the past seven years has worked as a community wound care nurse managing complex wounds. She belongs to the New Zealand wound care society and attended this organisations conference in 2013. She reports that if she required advise or assistance around a wound she would consult with fellow members of the wound care society or the DHB wound nurse specialist. She reviews the wound care folders in each area each week and reviews all pressure areas at least weekly.

The service recently had five grade one and two pressure areas (all of which are now healed). A quality improvement plan including staff training was implemented and there have been no new pressure areas since this time.

#### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

#### **Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)**

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  There are six activity coordinators (two for the rest home, two for the hospital and two for the serviced apartments). 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 who entertains in the rest home and hospital.

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

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

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

All 14 residents (nine from the rest home, three from the hospital and two from serviced apartments) and seven family (five from the hospital, one from the rest home and one from a serviced apartment) 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 the care plan is reviewed.

**Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

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

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

**Attainment and Risk:** FA

**Evidence:**

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 (sighted). Short term care plans are well utilised in the rest home, hospital, and serviced apartments. Any changes to the long term care plan are dated and signed. Ten care plans reviewed (one resident is on respite care) included handwritten updates to the plan as needs have changed (also link 1.3.6.1).

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

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

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

### Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

### Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)**

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated by the service. The referral is co-ordinated by the registered nurses, when the referral is not to a specialist. A letter from the GP is then required.</p> <p>D16.4c; The service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care.</p> <p>D 20.1 Discussions with registered nurses identified that the service has access to speech language therapists, physiotherpaist, dietitans, podiatrist and hospital specialists.</p>

**Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)**

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

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

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Transfer information is completed by the registered nurse or clinical manager and communicated to support new providers. The information meets the individual needs of the transferred resident. The transfer of residents or admission to other providers policy includes instructions for documentation and whom to notify. One rest home file was reviewed of a resident transferred acutely to hospital identified that a transfer form was completed and family notified. Seven family (five from the hospital, one from the rest home and one from a serviced apartment) interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.

#### Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

### Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

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

**Attainment and Risk:** FA

**Evidence:**

The service uses individualised medication blister packs. The medications are delivered monthly and checked in by a registered nurse in the hospital and rest home. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications. Medication administration was observed at lunchtime. Medications and associated documentation is kept on the medication trolley in locked treatment

rooms in the two areas and in a locked cupboard in the serviced apartments.

Registered nurses and enrolled nurses in the hospital and senior caregivers/ registered nurses in the rest home and enrolled nurses or senior caregivers in the serviced apartments deemed competent are responsible for administering medication. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.

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

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

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

There is a self-medicating residents policy in place. A self-medication assessment checklist is available and has been completed and reviewed six monthly for the three residents who self-administer (one resident fully self administers, one self administers voltarin emugel and one self administers inhalers and suppliment drinks).

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

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

#### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>



**Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)**

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

**Attainment and Risk:** FA

**Evidence:**

All kitchen staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller and a pantry. The menu is designed and reviewed by a registered dietitian at an organisational level. There is a three monthly rolling menu. All meals are cooked in the main kitchen and are transferred to the rest home, hospital and serviced apartments in insulated containers. Trays of food are then removed from the insulated transfer boxes and placed in warmed bain maries. Caregivers serve the food from bain maries in kitchenette areas in each unit. There are also snacks available over 24 hours for residents. Diets are modified as required. There are currently two gluten free, one vegetarian and two XXXXX residents being catered for. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed by XXXXXX . 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 100% in July 2013. Residents with special dietary needs have a nutritional profile completed on admission. This is reviewed six monthly as part of the care plan review. Changes to residents dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the kitchen notice board which is able to be viewed only by kitchen staff.

#### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

## **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.

## Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

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

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

**Attainment and Risk:** FA

**Evidence:**

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

### Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

### Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

**Attainment and Risk:** FA

**Evidence:**

Legislation and regulatory requirements appear to be met for local authorities and the MoH. Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which expires on 13 November 2013. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2013. Health and Safety meetings include maintenance and preventative maintenance. Electrical testing last occurred in 28 May 2013 (due two yearly). Hoists were last checked in September 2013 and all medical equipment was calibrated at this time also. Hot water is checked three monthly and records show these are maintained within safe limits.

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

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

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

### Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

#### Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

#### Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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

ARC E3.3d ARHSS D15.3c

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms have ensuites. Communal toilets are located near

the lounges. The service is divided into two areas - hospital upstairs and rest home/hospital on the level below and the serviced apartment's wings.

**Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Residents rooms are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. The lounge areas in each wing are spacious. Residents and family report satisfaction with personal rooms.

**Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)**

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)**

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Each area has at least two lounges. There is also a family room and separate dining areas on each floor. The communal lounge/dining room in the serviced apartments is spacious and allows for a number of different activities. Residents were sighted accessing communal areas independantly and with assistance during the audit and all residents interviewed report satisfaction with communal areas.

**Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>



## Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

**Attainment and Risk:** FA

**Evidence:**

The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme. Linen service audit for March 2013 showed 100% compliance and housekeeping hygiene 100%. The service has a secure area for the storage of bulk cleaning and laundry chemicals in the laundry. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are displayed in the cleaning cupboards and there are secure chemical storage areas. The laundry and cleaning areas have hand-washing facilities.

### Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

### Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)**

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

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

**Attainment and Risk:** FA

**Evidence:**

D19.6: The Ryman group emergency and disaster manual includes dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Regular fire and emergency drills are completed – last in May 2013 (six monthly at least as sighted in the records of the 2012 and 2013 training). Emergencies and first aid is included in the mandatory in-services programme every two years and the annual training plan includes emergency training. The fire service evacuation plan was approved on 11 December 2002. The service has alternative cooking facilities (two gas cookers) available in the event of a power failure. Battery operated emergency lighting is in place and this is tested throughout the year internally and externally by contracted company. Extra blankets are available. There is a civil defence kit for the whole facility and this is checked with results recorded through the audit process. There is water storage available (tanks in the ceiling). There is a civil defence folder that includes procedures specific to the facility and organisation. There are environmental audits (last completed in June 2013 – 99% compliance), audits of the emergency call bells testing and smoke detector with battery change last in February 2103 (100% compliance). Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. Senior caregivers carry a pager and all calls are signalled on a screen with the room number at varied places throughout the facility (this includes serviced apartment rooms). The serviced apartments also have call bells. Call bells were observed to be answered in a timely manner throughout the facility on the days of the audit. Residents state that bells are answered within a maximum of five minutes. The entire facility is secured at night. Visitor’s book and resident sign out book available. The Ryman group has security checks policy and procedure. Staff have completed training around acting with urgency – last in September 2013.

### **Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)**

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility. All rooms have external windows with plenty of natural sunlight. Residents and families interviewed reported positively about temperatures and the amount of natural light within the facility.

**Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

### Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a restraint minimisation manual applicable to the type and size of the service.. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.

The restraint minimisation manual includes that enablers are voluntary and the least restrictive option. There are no enablers and no restraints used in the service.

The clinical manager states that the service has reviewed all residents using restraint and enablers following her appointment to the service in line with reducing harm from the use of restraints particularly (bruises) with an assessment for restraint removal completed for all (sighted in four hospital files reviewed where residents had restraint in place). A review of four files where restraint had been in place indicates that there has been a successful trial following the removal of restraints with no increase in falls or bruising or other incidents.

A review of incident forms since the removal of restraints and enablers shows a decrease in bruising that may be related to better monitoring of residents following the removal of the restraint (as stated by caregivers interviewed who state that they are observing residents more frequently and as confirmed by the clinical manager and the assistant manager).

An emphasis has been placed on training around restraint and enablers (last in April 2013), falls prevention and analysis (Last provided in September 2013), assessing/managing/monitoring behavioural problems and management of challenging behaviour (last provided in August 2013).

There is a restraint approval group at Grace Joel that oversees restraint minimisation practices with meetings occurring six monthly and as required

### Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

### Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

**Attainment and Risk:** Not Applicable

**Evidence:**

### Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

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

**Attainment and Risk:** Not Applicable

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

## Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

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

**Attainment and Risk:** Not Applicable

**Evidence:**

### Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

**Attainment and Risk:** Not Applicable

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*



### Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

**Attainment and Risk:** Not Applicable

**Evidence:**

#### Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**Attainment and Risk:** Not Applicable

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

**Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

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

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

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

**Attainment and Risk:** Not Applicable

**Evidence:**

### Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

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

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

**Attainment and Risk:** Not Applicable

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

**Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

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

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)**

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

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

<b>Attainment and Risk:</b> Not Audited
<b>Evidence:</b>

### Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

<b>Attainment and Risk:</b> Not Applicable
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

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### Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There are policies including a) a scope and application of the NZ standard for IC policy, b) infection control management policy, c) infection control governance policy, and d) defined and documented IC programme policy. There are clear lines of accountability to report to the infection control (IC), team on any infection control issues including a reporting and notification to head office policy. There is an infection control responsibility policy that includes chain of responsibility and an infection control officer job description.

The defined and documented IC programme policy states that the infection control programme is set out annually from head office and is directed via the Ryman Accreditation Programmes annual calendar.

The annual review policy states IC is an agenda item on the two monthly head office health and safety committee. Grace Joel also undertakes a six monthly comparative summary report on all infections that is reported to staff (last completed in March 2013).

The service infection control manual includes a policy on a) admission of resident with potential or actual infections policy, b) infectious hazards to staff policy, c) outbreak management d) staff health policy and e) isolation policy.

The clinical manager who oversees the infection control coordinator (registered nurse) could describe how they would manage an outbreak and there are individual policies such as scabies management policy (note that the infection control coordinator – registered nurse is not on duty on the days of the audit). There have been no outbreaks since the previous audit.

**Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

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

ARC D5.4e ARHSS D5.4e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are terms of reference for the health and safety committee that includes discussion of infection control. The infection control coordinator (registered nurse) facilitates the surveillance programme with reports around data provided, organizes training with Med lab, Auckland DHB and other IC specialists, implements and reviews internal audits as evident in documentation reviewed. The infection control coordinator has completed the infection control MoH training on line and the programme has oversight from the clinical manager.</p> <p>The infection control coordinator has access to the general practitioners, infection control nurse specialist in the DHB, the wound nurse specialist on site two days a week and to other senior staff including the regional manager to undertake surveillance, audits, laboratory results, investigation.</p> <p>The clinical manager confirms that she is supporting the infection control coordinator in the role.</p>

### Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)**

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>There are comprehensive infection control policies that support the Infection Control Standard SNZ HB 8134:2008. There are modified dates identified for all infection control policies and procedures. Policies are documented as currently being reviewed in October 2013. The policies include written material relevant to the service. The infection control policies link to other documentation and uses references where appropriate.</p> <p>There are policies for IC management, b) implementing the IC programme, c) education, d) surveillance, and e) overall IC general policies and procedures</p> <p>D 19.2a: Infection control policies include a) hand hygiene policies including antiseptic and routine or social. There are also diagrammatic instructions, b) standard precautions policy including hand washing, gloves, barrier protection, additional precautions for highly transmissible pathogens, assessment of staff compliance, isolation, cohorting, transport of infected residents, resident and visitor education and handling of linen, equipment and waste;</p> <p>c) transmission based precautions policies in place including infectious hazards to staff policy, d) staff health policy and staff health guidelines, e) antimicrobial usage policy, f) outbreak management policies and procedures, g) cleaning, disinfection and sterilising of equipment policy, decontamination policy, disinfections policy, h) single use items policy, and i) construction projects/renovations policy.</p> <p>Thirteen caregivers interviewed (seven hospital, six rest home, two serviced apartments with staff across AM, PM and night shift), one enrolled nurse, the serviced apartment coordinator (enrolled nurse) and three registered nurses (one hospital and two rest home) confirm their knowledge of the infection control programme.</p>

**Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>



**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **Standard 3.4: Education (HDS(IPC)S.2008:3.4)**

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

Infection control training is provided by the infection control officer along with training when available from other specialists in the area e.g. the wound nurse specialist. Training in 2013 has included infection control (September 2013), safe food handling (August 2013), food safe practices (November 2012); wound care management including practical aspects of technique – May 2013.  
Resident education is expected to occur as part of providing daily cares.  
Support plans can include ways to assist staff in ensuring this occurs.  
Resident and relative meeting minutes include feedback on infection prevention and control.  
13 caregivers interviewed (seven hospital, six rest home, two serviced apartments with staff across AM, PM and night shift) describe good IC practices associated with their descriptions of care provided.  
The clinical manager describes sound infection control practices being overseen by the registered nurses.  
Good practice was observed to occur on the days of the audit with staff washing hands appropriately before serving food and before and after cares.

### **Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The surveillance policy states the routine/planned surveillance programme is organised and promoted via the RAP calendar. The health and safety committee meets two monthly and also acts as the infection control committee. A monthly infection summary report is completed. Review of the minutes indicates that any trends are discussed with improvements made.</p> <p>The surveillance includes a) systematic surveillance, b) response to surveillance activities, c) development of the surveillance programme, d) standardised definitions, e) surveillance methods, f) reports and g) assessment of effectiveness of surveillance.</p> <p>Surveillance methods and processes including implementation of an internal audit are appropriate for the size of this facility (rest home and hospital level). All infections are collected via the 'infection report form' and all collected and discussed at the RAP meetings. Following this the report information is entered onto the VCare system and a collated report of generated.</p> <p>Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.</p> <p>The infection control coordinator then completes a monthly infection summary which is discussed at bimonthly health and safety meetings and a six monthly comparative summary is completed and forwarded to head office.</p> <p>All meetings held at Grace Joel include discussion on infection control.</p> <p>Internal audits are completed as follows: hand washing audit – April 2013 100%, housekeeping – March 2013 100%, laundry hygiene audit -.March 2013 100%, kitchen hygiene audit – July 2013 100% compliance.</p> <p>Infections are benchmarked across the organisation.</p>

**Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>