# Julia Wallace Retirement Village Limited

## Current Status: 7 November 2013

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

## General overview

Julia Wallace Retirement Village is operated by Ryman Healthcare Ltd. and provides care for up to 104 residents. The service is certified to provide three service levels; hospital –geriatric/medical, rest home care and dementia level of care. Occupancy during the audit was at 94 residents, including 21 residents in dementia unit, 43 hospital and 30 rest home residents. There are 20 serviced apartments certified to provide rest home level care. There are currently 10 rest home residents in the serviced apartments.

Ryman Healthcare Ltd. has an organisational quality and risk management system and service objectives. The quality system continues to be implemented at the facility. Julia Wallace Retirement Village is managed by a village manager, who is supported by an assistant manager and a clinical manager (registered nurse).

This surveillance audit includes a review of the aspects of service provision identified in the previous audit as requiring improvement. The service has addressed two of the four previous shortfalls. Improvements continue to be required around aspects of care planning and medication management.

This audit also identified four further improvements required around family involvement, activities, review of care plans and food services.

## Audit Summary as at 7 November 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 7 November 2013

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

### Organisational Management as at 7 November 2013

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 7 November 2013

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

### Safe and Appropriate Environment as at 7 November 2013

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

### Restraint Minimisation and Safe Practice as at 7 November 2013

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 7 November 2013

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| 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. |

# HealthCERT Aged Residential Care Audit Report (version 3.9)

## **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**

|  |  |
| --- | --- |
| **Legal entity name:** | Ryman Healthcare Ltd. |
| **Certificate name:** | Julia Wallace Retirement Village |

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| **Designated Auditing Agency:** | HDANZ |

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| **Types of audit:** |  Surveillance |
| **Premises audited:** | Julia Wallace ; 28 Dogwood Way, Clearview Park, Palmerston North |
| **Services audited:** | Hospital (geriatric/medical); Rest Home; Dementia |
| **Dates of audit:** | **Start date:** | 7 November 2013 | **End date:** | 8 November 2013 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 94 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 9 | Total audit hours | 33 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 10 | Number of staff interviewed | 20 | Number of managers interviewed | 4 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 9 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 50 | Number of relatives interviewed | 5 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | 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:

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| --- | --- | --- |
| 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 | Yes |
| 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, 4 December 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Julia Wallace Retirement Village is operated by Ryman Healthcare Ltd. and provides care for up to 104 residents. The service is certified to provide three service levels; hospital –geriatric/medical, rest home care and dementia level of care. Occupancy during the audit was at 94 residents, including 21 residents in dementia unit, 43 hospital and 30 rest home residents. There are 20 serviced apartments certified to provide rest home level care. There are currently 10 rest home residents in the serviced apartments. Ryman Healthcare Ltd. has an organisational quality and risk management system and service objectives. The quality system continues to be implemented at the facility. Julia Wallace Retirement Village is managed by a village manager, who is supported by an assistant manager and a clinical manager (registered nurse).This surveillance audit includes a review of the aspects of service provision identified in the previous audit as requiring improvement. The service has addressed two of of the four previous shortfalls. Improvements continue to be required around aspects of care planning and medication management.This audit also identified four further mprovements required around family involvement, activities, review of care plans and food services. |

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| **Outcome 1.1: Consumer Rights** |
| Open disclosure policy and procedures are in place to ensure staff maintain open and transparent communication with residents and their family. Resident files provide evidence communication with family occurs when required. Relative interviews confirm relatives are kept fully informed.The Code of Health and Disability Services Consumers' Rights (the Code) information is displayed throughout the facility, along with complaint forms. There is a complaint register in place. The complaint processes are documented and there is evidence of complaints follow up, action taken and resolution, according to policy timeframes. The village manager advises there is currently one investigation underway by the District Health Board, relating to charges for premium rooms, however there have been no other complaints investigated by the Health and Disability Commissioner, Police, Ministry of Health, Coroner and ACC since the previous audit at this facility. |

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| **Outcome 1.2: Organisational Management** |
| Ryman Healthcare Ltd. has a quality and risk management system in place, that is implemented at Julia Wallace Retirement Village.The quality monitoring programme includes, (but is not limited to); infection control, audis and quality improvements, health and safety, service delivery, resident rights, emergency and human resources. Monitoring is completed, as designated by the Ryman Accreditation Programme schedule (RAP), to demonstrate implementation of the quality programme. Six monthly benchmarking reports, produced by the Head Office, provide comparisons with other Ryman facilities. Quality and risk performance is reported on at the facility meetings. Ryman Healthcare Ltd. head office staff provide support to the facility.The village manager has been in this position since May 2013. The village manager is supported by an assitant manager and a clinical manager, registered nurse. The village manager, assistant manager and the clinical manager have undertaken orientation and training in relevant areas to their positions. There is an internal audit programme to monitor all areas of service delivery. There is a hazard register. Adverse events are documented on accident/incident forms and reviewed by management. Completed accident/incident forms are retained in individual resident files. Internal audits, accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans are developed, implemented and signed off as being completed to address the issue/s that require improvement.Meeting minutes evidence reporting on number of various clinical indicators, quality and risk issues, and discussion of any trends identified.There are policies and procedures on human resources management and the validation of current annual practising certificates for staff that require them is occurring. Staff in-service education sessions are provided and staff are supported to attend external education, as appropriate. Review of staff education records evidence individual education records are maintained. There is a policy for determining staffing and skill mix for safe service delivery. Rosters sighted evidence adherence to policy and staff skill mix guidelines.An annual resident and relative satisfaction survey is completed and there are regular resident meetings at the facility. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The registered nurse is responsible for each stage of service provision. Enrolled nurses and registered nurses develop and review care plans and the RN reads and countersigns care plans completed by enrolled nurses. This previous shortfall has been addressed. The assessments, initial and long term nursing care plans are implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. Evidence of resident/family/whanau participation in the care planning process is required. The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. Overall the residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is an improvement required to ensure behavioural care plans are reviewed six monthly and outcomes/interventions from medical professionals are documented in the care plans. Daily progress notes document all aspects of the residents care over a 24 hour period. Resident files are integrated and include notes by the GP and allied health professionals. The GP reviews the resident at least three monthly.The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the resident group. Spiritual and cultural preferences and needs are being met. There is an improvement required to ensure the individual activity care plan for dementia care residents covers a 24 hour period. Education and medicines competencies are completed by all staff responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities. There is weekly stock check of controlled drugs. There is an improvement in medication documentation since the previous audit. There is an improvement required around the use of standing orders. Food services and all meals are provided on site and transported to hospital wing and dementia unit in hot boxes. There is an improvement required to ensure residents individual food preferences and likes and dislikes are known to the carers who serve the meals. All perishable foods in the fridges are dated. This is an improvement from the previous audit. The menu is designed by the company dietitian. All staff are trained in food safety and hygiene. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has a current building warrant of fitness. There is an approved fire evacuation scheme. A reactive and preventative planned maintenance schedule is in place. The outdoor areas and gardens are well maintained. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are six residents assessed as requiring enablers and nine residents requiring restraints. The restraint minimisation policies and procedures include assessment of the least restrictive option, consent, monitoring and evaluation of enablers and restraint. There is a restraint approval group at Julia Wallace Retirement Village, that meets quarterly to oversee restraint and enabler practices at the facility. |

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| **Outcome 3: Infection Prevention and Control** |
| The Infection Prevention and Control (IC) Programme includes policies and procedures for the prevention and minimisation of infection and cross infection. The IC policies and procedures guide staff in all areas of infection control practice. The Infection Control team is integrated as part of the two monthly infection control/health & safety meeting. There is an infection control register in which all infections are documented. A monthly infection control report is completed and forwarded to Ryman Healthcare Ltd. head office for analysis and benchmarking. A six monthly comparative summary is completed.  |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 11 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 4 | 1 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | i) One dementia care resident behavioural nursing care plan has not been evaluated six monthly. There is no evidence of family involvement in the review of behavioural care plans for two dementia care residents and one rest home resident | i) Ensure behavioural care plans are reviewed six monthly; (ii) ensure family involvement in behavioural care plans is evidenced. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Two of six files did not align with required interventions, this remains a required improvement: eg: i) The weight loss short term care plan for a dementia care resident has not been updated with the outcome of the GP visit. ii) There is no short term care plan for hospital resident with medical and dietary changes following discharge from hospital as per the discharge summary.  | Ensure care plans reflect the resident current medical needs and requirements. | 60 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.7.1 | Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | ARC E4.2; The two dementia activity care plans did not specifically link to the assessment and cover activities across the 24 hours  | Ensure activity care plans for dementia care residents cover the 24 hour period. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The standing orders for one GP is filed in the policy folder and not readily accessible in the medication folder for the administration of standing orders. | Ensure the standing orders are readily available in the medication folders and only administered as authorised by the one GP. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.2 | Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | There is no evidence of resident food preferences, likes or dislikes available to carers serving meals in the rest home, hospital or special care unit. | Ensure resident food preferences, likes or dislikes are known to staff to ensure resident dietary needs are met. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

#### Standard 1.1.1: Consumer Rights During Service Delivery **(**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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Open disclosure policy is in place to ensure staff maintain open and transparent communication with residents and their families. Residents' files reviewed provide evidence that communication with family is occurring. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms and progress notes. Residents interviewed confirm that staff communicate well with them and are aware of the staff who are responsible for their care. The Code of Health and Disability Services Consumers' Rights (the Code) information is displayed throughout the facility, along with complaint forms.Staff in-service education on open disclosure and advocacy was conducted in October 2013 and 20 staff attended.Family meetings are conducted and sighted meeting minutes for the rest home and hospital care centre for May 2013. Special care unit meeting minutes for June 2013 were also sighted. An annual resident and relative satisfaction survey is completed and there are regular resident meetings, sighted.Six admission agreements for six permanent residents and two admission agreements for respite residents were reviewed and all eight admission agreements evidence sign off and documentation of additional charges for premium rooms.The related ARC requirements are met. |

##### **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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)**

Consumers have access to visitors of their choice.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented complaints management procedure in place. The complaint process is in a format that is understood and accessible to residents and family, confirmed at resident and family interviews. The compliants are recorded on the complaints register and an assessment of the risk associated with the complaint is made, as per the complaints reporting severity matrix and associated timeframes. All medium and above risk rating of compliants are reported to the regional manager. Complaints are entered on the patient management software (VCARE), as an event to analyse levels of resident disatisfaction and monitor trends. Quarterly reports are generated from VCARE to monitor complaints, stated by the manager. The complaints register for 2013 records two written complaints in the rest home. One of the two complaints is a recent care complaint, which is in progress and adhering to timeframes. The second complaint relates to staff and this is closed.The complaints register evidences there are five written and four verbal complaints in the hospital. The five written complaints relate to; two to service delivery; one to other, two to staff and food, and all complaints are resolved according to timeframes. The verbal complaints in hospital relate to; three around service delivery and one around staff and food. Two verbal complaints are still in progress and timeframes and correspondence is adhered to.There is one written complaint on the register for the secure unit relating to staff and this is fully resolved.Staff in-service education in relation to complaints and professional boundaries was conducted in June 2013 and attended by 24 staff.The village manager reports there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, Police, Accident Compensation Corporation (ACC) and Coroner since the previous audit at this facility, however advises there is currently one District Health Board investigation underway that relates to the circumstances surrounding charging of fees for premium rooms. There are no records at the facility pertaining to this investigation, as this is being conducted with the DHB staff and the operations manager. The village manager also advises that Ryman Healthcare Ltd. head office staff are participating in this investigation. This complaint was reported directly to Ryman head office, hence there are no records of this complaint on the complaints register, states the village manager. The village manager states the DHB staff have conducted a visit to the facility and also conducted interview with the village manager.The related ARC requirements are met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

## **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The governing body, Ryman Healthcare Ltd. has established systems in place, which define the purpose, values, scope, direction and goals of the organisation and the facility, and the monitoring and reporting processes against these systems. The quality monitoring programme, the Ryman Accreditation Programme (RAP) monitors contractual and standards compliance in the facility.Julia Wallace Retirement Village is a purpose built facility, that is part of a wider village. It provides care for up to 104 residents requiring hospital (geriatric and medical), rest home or dementia level care. The care centre (63 beds) includes the rest home and hospital rooms. The 21 bed secure dementia unit is on the 1st floor. Additionally, there are 20 serviced apartments certified to provide rest home level care.There are 10 rest home residents in the serviced apartments on audit days. On the day of the audit, there were 43 hospital residents, 30 rest home residents and 21 residents in the secure care unit.The village manager’s position is directly accountable to the Operations Manager and the Managing Director of Ryman Healthcare Ltd. There is a documented position description for the village manager and responsibilities protocol for the manager to adhere to. The village manager states full orientation and induction was conducted, however this could not be verifed at the audit, as the village manager’s personal file is kept at the Ryman Healthcare Ltd. head office.The village manager is qualified as a medical technologist and states, past professional experience consists of working as a medical technologist (approximately six years); self employment in direct selling industry (approximately 20 years); recruitment consultant (approximately one year); training and area manager for Red Cross (approximate 14 months ); Lifelink area manager for St. Johns and responsible for First Aid training ( approximately five years); Bupa care services regional manager for medical alarm services ( approximately two years) prior to taking up the appointment as the village manager at Julia Wallace in May 2013. The village manager’s training since employment, relevant to the position includes, the village managers’ leadership day, attended in October 2013.The village manager is supported by an assistant manager. The assistant manager was appointed to this position in June 2013. Interview with the assistant manager confirms past employment and experience as a manager of a private orthopaedic practice and manager of injury rehabilitation practice. The assistant manager has a business certificate. The assistant manager position is a new position for Ryman Healthcare. The assistant manager states this position includes responsibilty for rosters, laundry, housekeeping, assisting with human resources and appointments of non clinical staff. This position is for 30 hours a week. Interview with the assistant manager confirms full orientation and management induction to the role was conducted, confirmed in staff file review. Assistant managers’ day was attended in July 2013 for all new assistant managers at Ryman Healthcare Ltd.The clinical manager was appointed to this position in January 2013. The clinical manager is a registered nurse and holds a current annual practising certificate. Past experience of the clinical manager includes; four years in residential care facility, including three years in a manager’s position and prior to this appointment two years working in coronary care unit. The clinical manager interview confirms induction and orientation was completed, verified in staff file reviewed. The clinical manager also hold the position of the infection control co-ordinator and states orientation and training to this position has occurred. An additional role the clinical manager holds is one of in-service co-ordinator, with responsibility for in-service presentations and arranging speakers. The clinical manager is a member of a external palliative resource group that meet three monthly and has attended palliative care study days since appointment to this position.Review of personal files and education records for the assistant and clinical manager, as well as interviews of both managers, indicate they have undertaken training in relevant areas. Support for the village and the assistant manager is provided by the regional manager for Ryman Healthcare Ltd. The related ARC requirements are met. |

##### **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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Julia Wallace Retirement Village has an established quality and risk management system, that is directed by Ryman head office. The monitoring programme includes all relevant clinical and non clinical service areas and this is completed monthly, six monthly or annually, as designated by the Ryman Accreditation Programme (RAP) programme schedule. This is monitored and reviewed through reporting to head office. Benchmarking reports are generated to review performance over a six month period. Reports and implementation of the quality system is monitored closely by head office. The quality and risk management plan/policy identifies the organization’s quality goals, objectives and scope of service delivery. Sighted Ryman Head Office Operations Team Objectives for 2013. Formal review of the RAP objectives and quality and risk management objectives occurs annually. Completed internal audits for 2013 reviewed along with clinical indicators for 2013.Julia Wallace Retirement Village objectives for 2013 were sighted. The Quality Improvement plan for 2013 was sighted and evidences six monthly progress report towards meeting the facility’s objectives.Meetings schedulle at the facility records frequency of meetings held. There are regular staff meetings, resident meetings,family, health and safety meetigs, and RN meetings. Meeting minutes reviewed and staff interviewed state minutes of meetings are available for review by staff. Sighted weekly clinical / management meeting minutes for October 2013.Internal audit register for 2013 was sighted along with completed audit outcomes for the year. A corrective action plan is developed for any audit, which has the overall compliance of 89 % or below. Depending on level of risk, a corrective action plan is developed evn if the overall compliance is 91% or highter. The results of audits with compliance of 89% or below are sent to Ryman head office monthly.There is documented evidence of collection, collation, and reporting of quality improvement data including reporting on quality and risk issues, and discussion of any trends identified in the weekly clinical/ management meetings. Staff interviewed (nine care givers working morning and afternoon shifts in all areas (two of the care givers also work nights), three RN's covering all three shifts, and the clinical manager) report they are kept informed of quality and risk management issues including clinical indicators. Health and safety policies are implemented and monitored by two monthly health and safety committee meetings. Risk management, hazard control and emergency policies and procedures are in place. Hazard identification and control is up to date with a hazard register in place. Staff in-service on health and safety, emergency and disaster management was conducted in August 2013 and attended by 34 staff. Waste management in–service education was conducted in August 2013 and attended by 20 staff. Chemical safety training / education was presented in June 2013 and attended by 19 staff.The requirements of the ARC are met. |

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The adverse event reporting system evidences a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form, which are then filed in resident files. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Staff can describe the incident reporting process and their role. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes.There is evidence of analysis of accident / incident data for trends reviewed in meeting minutes and confirmed during interviews of staff.A review of incident/accident forms identifies they are fully completed and include follow-up actions. A falls response protocol was completed where required.Resident files reviewed provide evidence of communication with family and GP on the incident/accident form and in resident progress notes. Evidence also reviewed during this audit of notification to family of any change in the resident’s condition. This finding is confirmed during interviews of residents and family.The ARC requirements are met. |

##### **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.

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

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Review of the 2013 in-service education planner and staff education records provide evidence of a planned in-service education at the facility. Interview with the in-service co-ordinator confirms that Ryman head office provide the facility with resources to support the in-service programme monthly. Staff education and training includes the aged care education (ACE) programme for caregivers. There are 14 caregivers in the dementia unit. 12 care givers have completed the required dementia standards and two are in the process of completing the standards.Registered nurses/enrolled nurses participate in the Ryman nursing journal club that meets monthly. Registered nurses (RNs) are supported to maintain their professional competency. Ryman provide a journal club for managers, with focus on management articles, stated by the village manager. The facility also participates in the Hospice resource group, of which the clinical manager is a member.Ongoing staff comprehension questionnaires are completed throughout the year, as part of ongoing education and competency assessments. There are comprehension surveys for all staff (health & safety, fire, emergency procedures, on call, house rules, incidents, infection control, privacy, abuse and neglect, communication and complaints). There are also specific comprehension surveys for care staff, food service staff, registered nurses (RNs) and enrolled nurses (ENs). The medication knowledge comprehension survey is conducted twice a year for staff that administer medicines.A review of nine staff records provide evidence human resource processes are followed and are completed. An appraisal schedule is in place and current staff appraisals were sighted in all staff files reviewed. Annual practising certificates are current for all staff who require them to practice. An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. There are job descriptions available for all positions and employment contracts are in place. Twenty of 20 staff interviewed confirm they have completed an orientation, including competency assessments (as appropriate). Clinical staff confirm their attendance at on-going in-service education and currency of their performance appraisals.The ARC requirements are met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

##### **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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staffing levels and skills mix policy documents the rationale for safe service delivery. The policy records staffing ratios to residents in the hospital, rest home and dementia unit and service apartments. Rosters reviewed evidence implementation of the documented staffing and skills mix rationale. Registered nurse cover is provided 24 hours a day, seven days a week. The care centre (rest home and hospital) and the secure unit is co-ordinated by the clinical manager (RN). The serviced apartments are co-ordinated by the service apartments co-ordinator (EN). The minimum amount of staff on duty at any one time is during the night shift and consists of one registered nurse and six caregivers. The village manager and the clinical manager rotate week about for the after hours on-call cover. Staff report they work well as a team to provide assistance to each other. The staff in the care centre care for the rest home residents in the serviced apartments after 9 pm daily. Call bells in the serviced apartments are linked throughout the facility.The village manager states Ryman Healthcare Ltd. have created three new positions of unit co-ordinators for the rest home, hospital and secure unit. These three positions have been filled and the new staff (all RNs) will commence employment in December 2013. The new unit co-ordinator in the hospital (RN) and the service apartments co-ordinator (EN) will be rostered to work from Sunday to Thursday. The new unit co-ordinators for the rest home and dementia unit will be rostered to work from Tuesday to Saturday. This roster will ensure there are two co-ordinators on duty during weekends. The village manager states there is only one staff vacancy presently, for a rest home diversional therapist.ARC requirements are met. |

##### **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.

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

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

All records pertaining to individual consumer service delivery are integrated.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs of admission. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy.The nursing care assessment, service delivery policy, care planning and interventions policy describes the responsibility around documentation. 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. RN's (interviewed) know the timeframes for the development and reviews of care plans. RN’s read and sign care plans, assessments and reviews undertaken by enrolled nurses in the rest home/serviced apartments. This is an improvement from the previous audit. Clinical staff have attended in-service and refreshers on clinical care including person centred care, skin integrity, personal hygiene, Liverpool care pathway, first aid and challenging behaviour. Activity assessments and activities care plans have been completed by the activity co-ordinators.A physiotherapist is contracted to the service 12 hours a week and a physiotherapy assistant works Monday to Friday. The physiotherapist (interviewed) undertakes new resident physiotherapy assessments, completes resident mobility reviews and follow ups any referrals from the three levels of care. The physiotherapist assistant (interviewed) carries out the instructions of the physiotherapist, walks one person residents daily, and assists caregivers/physio with two person walks. Physiotherapy progress notes, physio mobility assessments and reviews are kept in the integrated residents files. Any changes in mobility status is reported to the RN and the care plan is updated. Mobility changes are written onto the duty handover form and communicated to staff at handover. This is an improvement from the previous audit. The podiatrist visits regularly. There is access to the company dietitian.  D16.2, 3, 4; An initial assessment and initial care plan is completed within the required timeframes. The long term care plan is reviewed by the registered nurses/enrolled nurses and amended when current health changes. All six files identify that evaluations of the long term care plans are completed six months. Two rest home (including one resident in the serviced apartment), two hospital and two dementia resident files were reviewed. All six long term files identified the initial admission assessments and plans and long term care plan were completed by the registered nurses (enrolled nurses in rest home and countersigned) within a three week timeframe. D16.5e; Medical assessments were documented in five long term files within 48 hours of admission. One resident was discharged from hospital with discharge prescription and discharge summary and seen by the general practitioner (GP) within 7 days. Three monthly medical reviews were documented in five of six files by the general practitioner. One resident has not been in the service three months. It was noted in the resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. More frequent medical assessment/ review noted occurring in residents with acute conditions and those with complex medical conditions. Medical care is mainly provided by GP’s from a local practice; however residents may retain their own GP. The GP interviewed visits weekly and conducts three monthly reviews and visits residents of concern. The GP is notified in a timely manner of any changes to a resident’s health status by fax or phone. The clinical manager and village manager have the GP’s mobile number for more urgent concerns. The GP is available after hours for any resident on the Liverpool care pathway. The GP stated there has been an improvement in communication and clinical assessments over recent months. After hours medical care is provided by City Doctors or Midcentral Emergency department for more urgent attention. The psychiatrist for Elder health and the community nurse practitioner visit the facility regularly and by referral, as required. Assessment tools completed on admission include a) Waterlow pressure area risk assessment, b) skin integrity, c) continence/three day diary, d) coombes falls risk, e) dietary requirements (link 1.3.13.2), f) pain/Abbey scale assessment, g) physiotherapy assessment, and h) behavioural assessment. Assessments are reviewed when there is a change to condition or at least six monthly. Nine caregivers (five rest home/hospital and four dementia care) interviewed could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. There is a communication book and Duty Handover form which is completed for each shift that lists any residents requiring any special observations or needs. Progress notes are written on every shift.Tracer methodology: Dementia care resident.XXXXXX *This information has been deleted as it is specific to the health care of a resident.*Tracer Methodology: Hospital level resident.XXXXXX *This information has been deleted as it is specific to the health care of a resident*Tracer Methodology: Rest Home resident.XXXXXX *This information has been deleted as it is specific to the health care of a resident* |

##### **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.

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

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| D16.2, 3, 4; An initial assessment and initial care plan is completed within the required timeframes. The long term care plan is reviewed by the registered nurses/enrolled nurses and amended when current health changes. All six files identify that evaluations of the long term care plans are completed six months. Two rest home (including one resident in the serviced apartment), two hospital and two dementia resident files were reviewed. All six long term files identified the initial admission assessments and plans and long term care plan were completed by the registered nurses (enrolled nurses in rest home and countersigned) within a three week timeframe. Resident/family sign and acknowledgment of involvement in the long term care plans. The behavioural care plans are an additional care plan as required.  |
| **Finding:** |
| i) One dementia care resident behavioural nursing care plan has not been evaluated six monthly. There is no evidence of family involvement in the review of behavioural care plans for two dementia care residents and one rest home resident |
| **Corrective Action:** |
| i) Ensure behavioural care plans are reviewed six monthly; (ii) ensure family involvement in behavioural care plans is evidenced. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Six resident files were reviewed (two rest home, two hospital and two dementia care unit).Residents interviewed (five hospital, five rest home) report their needs are being appropriately met. Relatives interviewed (four hospital, one dementia care) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. Care plan includes; cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, medication, ADLs, skin, wound and pressure care, pain, dietary/diabetes management, and social, spiritual, cultural and sexuality. Interview with three registered nurses and one enrolled nurse verified involvement of families in the care planning process. Relatives interviewed confirm they are informed of any changes (during visit, phone or email) to their relative’s health and interventions required to meet the resident’s needs. There is evidence in the progress notes (with a relative contact stamp) that next of kin have been contacted and a record of the discussion held.D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and wound management plans/skin tear plans are in place for five skin tears, three leg ulcers and one toe ulcer (rest home/hospital level), one hand wound, two legs ulcers and two basal cell carcinomas, (dementia care unit). There are no wounds or skin tears in the serviced apartments (includes 10 rest home residents). Each unit has a wound folder and skin tear register. The RN countersigns EN wound assessments. There is evidence of a referral to the clinical nurse specialist for tissue viability. The clinical manager interviewed described access to district nurses or wound specialist by referral, as required. Continence products are available and resident files include a urinary continence assessment on initial assessment. A three day continence diary is initiated to determine continence products required for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager interviewed. Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an assessment form for at risk residents.  |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents are weighed monthly. Chair scales are calibrated annually. Short term weight loss/gain short term care plans are in place. Discharge summaries are received on transfer/discharge from hospital.  |
| **Finding:** |
| Two of six files did not align with required interventions, this remains a required improvement: eg: i) The weight loss short term care plan for a dementia care resident has not been updated with the outcome of the GP visit. ii) There is no short term care plan for hospital resident with medical and dietary changes following discharge from hospital as per the discharge summary.  |
| **Corrective Action:** |
| Ensure care plans reflect the resident current medical needs and requirements. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are two Diversional Therapists (DT) and three activity co-ordinators that provide separate activity programmes for the town houses, serviced apartments, rest home, hospital, and dementia care unit. The DT team report to the village manager. There is a seven day a week activity programme delivered in the dementia care unit. The programme is planned monthly at the DT meetings and residents receive a personal copy of the activities programme. Activities planners are displayed on notice boards around the facility. There is a core programme which includes the triple A (Active, Ageless, Awareness) exercise programme, that was designed by the Ryman group and includes exercises for less active residents and a more active exercise programme for mobile residents and serviced apartments. Triple A exercises for the more active is held in the large recreational room. The programme in the rest home includes floor games, group walks and more one on one activties. Quizzes, arts, pet and music therapy and cooking is enjoyed. In the dementia unit there are meaningful activities for the residents such as folding washing, dusting and floor games. Other activties for the demntia residents are massage, manicures, cooking, van drives and entertainment. There are combined entertainment and social afternoons open to residents from all units. Residents in the serviced apartments choose to attend activities, as desired. The dementia care unit has an oudoor courtyard with seating and raised gardens. The dementia care residents are taken on supervised walks outside in the main grounds and gardens (as seen on the day of audit). The comprehensive programmes in each unit meets the physical and cognitive abilities of the residents. Regular outings and drives are offered. The company has two vans and access the mobility taxis, as required. The activtity team are scheduled for first aid refreshers. Residents are encouraged to maintain links with the community such as; senior citizens, RSA and prime time (church group). Spiritual needs are met with weekly denominational church services and a monthly catholic communion. A minister associated with the home is available for the blessing of rooms and visiting residents. The resident has an activity assessment on admission with family involvement, if applicable and interests and hobbies etc. are discussed. An activity 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 and 'your life experiences'. The activity and clinical care plans are reviewed at least six monthly at the same time and include the resident/family, RN and activity co-ordinators. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. There is an improvement required around the activities plans in the dementia unit.A resident attendance list for activities, entertainment and outings is maintained. Resident participation is voluntary. One on one activities are provided for residents as assessed. Resident meetings are held and feedback to activities is provided at the meeting. The DT’s and activities co-ordinators attend all relevant on-site education. The DT’s receive newsletters and emails that provide information on activities, resources and upcoming events. All ten (five rest home and five hospital) residents and six (four hospital, one dementia care) family members interviewed are satisfied with the programme and the diversity offered to all residents. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two dementia care resident files reviewed included an individual assessment that identified wellbeing, outings, interests and hobbies and family and community interests. |
| **Finding:** |
| ARC E4.2; The two dementia activity care plans did not specifically link to the assessment and cover activities across the 24 hours  |
| **Corrective Action:** |
| Ensure activity care plans for dementia care residents cover the 24 hour period. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited in resident files). EN evaluations are countersigned by the RN. Short term care plans are utilised in the rest home, hospital, and dementia unit. Short term care plans sighted are for weight loss, skin tear, eye infection, chest infection, UTI. Short term care plans are evaluated at regular intervals and problems are either resolved or transferred to the long term care plan as an on-going problem. Any changes to the long term care plan are dated and signed. The activity assessments are reviewed six monthly. The GP conducts a three monthly resident review and medication review  |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. The service uses Douglas medico blister packs. The medications are delivered monthly and checked in by the RN. Any discrepancies are fed back to the pharmacy. Medication reconciliation for resident admissions and transfers are completed by the pharmacist. The main medication room is located in the rest home/hospital unit. The medication trolleys are kept in a locked treatment room in the rest home, hospital, dementia care unit and serviced apartments. RN's in the hospital, enrolled nurses in the rest home and senior caregivers are competency assessed six monthly. The standing orders for one GP is filed in the policy folder and not readily accessible in the medication folder for the administration of standing orders.There is a medication competency signature list. Medication education is attended annually. RN's complete syringe driver training and are supported by the local hospice nurses and specialist. Liverpool care pathway medications are kept in the controlled drug safe in the hospital unit. Controlled drugs are checked weekly and there is a pharmacy audit six monthly. Medication fridge temperatures are monitored weekly. There are locked returns cabinets in each unit. All eye drops in the medication trolleys are dated on opening. There are no expired medications. Administration signing sheets are correct and complete and PRN medications are listed on the 'As Required' (prn) signing sheet. This is an improvement from the previous audit. PRN medications have a time of administration recorded. Controlled drugs are signed as given by two medication competent staff. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. Medication administration observed in the dementia care unit complies with safe medication practice. There is one self-medicating rest home resident. There is a self-medication assessment and RN monitoring. The medication is stored in a locked drawer within the resident’s room. 12 of 12 medication charts sampled have photos and allergies/adverse reaction documented. 16.5.e.i.2; 12 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are current standing orders signed by one GP. This is an improvement from the previous audit, however a new partial attainment is raised in regards to standing orders |
| **Finding:** |
| The standing orders for one GP is filed in the policy folder and not readily accessible in the medication folder for the administration of standing orders. |
| **Corrective Action:** |
| Ensure the standing orders are readily available in the medication folders and only administered as authorised by the one GP. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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

##### **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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| 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. There is a cook, kitchen hand and dishwasher on daily. The four weekly summer and winter menu is designed and reviewed by a Registered Dietitian at an organisational level. Every resident received a copy of the reviewed summer menu. The cook receives a notification of resident dietary requirements for each new admission. Modified diets and special diets such as diabetic jellies are available. Breakfasts are served in the residents rooms. All meals are cooked in the main kitchen off the rest home dining room. The midday and evening meals are delivered in hot boxes to the hospital and special care unit kitchenettes and served from bainmaries. There is a three monthly audit of bain marie food temperatures completed. Corrective actions have not been required. Staff in the special care unit are observed seated while assisting residents with their meals. Special diets are name labelled. All perishable foods are date labelled in the hospital and special care unit fridges. This is an improvement from the previous audit. The service has a large workable kitchen that contains a walk-in chiller, freezers, walk-in pantry, electric stove and oven, two combi ovens and a deep fryer. All equipment has been checked. The kitchen work flow has defined areas for dishwashing, baking, cooking, delivery and storage areas. The freezer and chiller temperatures are recorded daily. All fridges in the kitchenettes are monitored daily. Perishable foods in the kitchen are date labelled. All dry goods in the pantry are sealed, dated and rotated with the delivery of food orders. Staff are observed wearing hats, aprons and gloves in the kitchen and kitchenette areas where food is served. Chemicals are stored safely. Fly screens are in place on the windows and external door. Feedback on the service is received from the resident and family meeting, satisfaction surveys and internal monitoring. There is a Food Comment diary in the rest home and hospital dining rooms are read daily by the cook. There is no evidence of resident food preferences, likes or dislikes available to carers serving meals in the rest home, hospital or special care unit.D19.2 staff have been trained in safe food handling. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Breakfast cards are available for staff to set up breakfast and serve to residents in their rooms. Caregivers serve meals from the bain maries in the hospital and rest home. |
| **Finding:** |
| There is no evidence of resident food preferences, likes or dislikes available to carers serving meals in the rest home, hospital or special care unit. |
| **Corrective Action:** |
| Ensure resident food preferences, likes or dislikes are known to staff to ensure resident dietary needs are met. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **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

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| --- |
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **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.

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| **Attainment and Risk:** Not Audited |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a current building warrant of fitness that expires 9 December 2013. A large purpose built recreational room and cinema has been constructed on the first floor (serviced apartments) since the previous audit. There is a fire service letter of evacuation approval dated 17 October 2013. There is a reactive and preventative maintenance programme. All clinical equipment has been checked and calibrated as required. There are monthly keypad door checks. Contracted electrical services conduct monthly lift inspections. Chubb fire service contractors monitor the fire safety equipment and conduct regular inspections. The external areas and grounds are well maintained. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **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.

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

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

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

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| **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 1.4.3: 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
|  |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **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 1.4.4: 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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 manoeuvre with the assistance of their aid within their personal space/bed area.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| --- |
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
|  |
| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

## **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has an overarching risk and quality management system, that demonstrates compliance with the Standard. Documented systems are in place to ensure the use of restraint is actively minimized. The definition of restraint and enabler is congruent with the definition in NZS 8134.0. The process of assessment and evaluation of enabler use is recorded. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. There is a restraint approval group at Julia Wallace Retirement Village, that meets quarterly to oversee restraint and enabler practices at the facility.The restraint minimisation manual identifies that enablers are voluntary and the least restrictive option. On the days of the audit, there were six residents assessed as requiring enablers and nine residents using restraints. The restraint / enabler monthly evaluation sheets were sighted and evidence documentation of the resident’s name, type of restraint, indication for use, family involvement, cultural requirements, number of occations in restraint / enabler and total number of hours of restraint / enabler and the impact on residents progress towards minimisation (alternatives to restraint used). Sighted restraint co-ordinator’s job description. Restraint meeting minutes for July 2013 were sighted. Staff interviews and staff records evidence guidance has been given on restraint practices, enabler usage and prevention and/or de-escalation techniques. Staff education on RMSP /Enabler and challenging behaviour was last conducted in August 2013 and attended by 36 staff. Restraint education was cnducted in April 2013 and attended by 29 staff. Current restraint competencies were sighted in staff files sampled. The ARC requirement is met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| --- |
| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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##### **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control (IC) programme / policy details surveillance processes relevant to the service setting and its complexity. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. The surveillance policy states the routine/planned surveillance programme is organised and promoted via Ryman RAP calendar. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection control monthly data is completed for each resident and includes type of infection, lab results, sensitivities, antibiotics prescribed, dose, duration, intervention, review and outcome. There is an IC register in which all infections are documented monthly. A six monthly comparative summary is completed by head office. Sighted IC six monthly comparative summary report for October 2012 to March 2013, recording trends in rest home, hospital and the dementia unit, recommendations and training provided. The IC co-ordinator states infections and any IC issues are discussed at weekly clinical / management meetings, verified at meeting minutes review.  |

##### **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.

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

##### **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.

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